BaylorScott&White
CARDIOVASCULAR CONSULTANTS
A member of HealthTexas Provider Network

Initial Office Visit - History

Patient's Name: ____________________ Gender: ☐ Male ☐ Female

Date of Birth: ____________________ Date of Visit: ____________________

Age: ____________________ Email address: ________________________________

Reason for Visit/Chief Complaint: (In your own words, why is it that you need to or want to see a heart specialist? What symptoms or sensations have you been experiencing? What questions do you want answered in today's visit?

Primary care physician: ____

Referring physician: ____

Other physicians whom you see: ____

Preferred Pharmacy: ____

Allergies: ❑ None ❑ Iodine ❑ Shellfish ❑ Medication allergies: ____________________

Medications:

Medication	Dose	Route	Frequency	Refill needed

Form Amended December 22, 2020 Reviewed by ______________ Date_________

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Past Medical History: (please place an "X" next to any condition that you have now or have had in the past)

Cardiac
- ❑ Abdominal aneurysm
- ❑ Anticoagulation – type ______________
- ❑ Atrial fibrillation
- ❑ Cardiomyopathy
- ❑ Carotid disease
- ❑ CHF/congestive heart failure
- ❑ Clotting disorder
- ❑ COPD
- ❑ Coronary artery disease
- ❑ Deep vein thrombosis
- ❑ Diabetes mellitus
- ❑ Heart attack
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Pulmonary embolus
- ❑ PVD/peripheral vascular disease
- ❑ Stroke/TIA
- ❑ Heart valve disease
- ❑ NONE OF THE ABOVE

Respiratory
- ❑ Asthma
- ❑ Chronic bronchitis
- ❑ Emphysema/COPD
- ❑ History of tobacco use
- ❑ NONE OF THE ABOVE

Gastrointestinal
- ❑ Crohn's disease
- ❑ Gastroesophageal reflux (stomach reflux)
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Hiatal hernia
- ❑ Stomach ulcers
- ❑ Ulcerative colitis
- ❑ NONE OF THE ABOVE

Hematologic/Oncologic
- ❑ Bleeding disorder
- ❑ Cancer – type _____________
- ❑ NONE OF THE ABOVE

Rheumatologic
- ❑ Autoimmune disease
- ❑ Gout
- ❑ Osteoarthritis
- ❑ Rheumatoid arthritis
- ❑ NONE OF THE ABOVE

Endocrine
- ❑ Diabetes
- ❑ Hyperthyroidism or Graves Disease
- ❑ Hypothyroidism
- ❑ NONE OF THE ABOVE

Infectious
- ❑ HIV/AIDS
- ❑ Rheumatic fever
- ❑ Syphilis
- ❑ NONE OF THE ABOVE

Neurologic/Psychiatric
- ❑ Anxiety
- ❑ Dementia/Alzheimer's
- ❑ Depression
- ❑ Parkinson's disease
- ❑ Seizure disorder
- ❑ NONE OF THE ABOVE

GU/Misc
- ❑ Breast disease
- ❑ Kidney failure
- ❑ Kidney stones
- ❑ Prostate disease
- ❑ NONE OF THE ABOVE

Other
- ❑ ____________________

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Past Surgical History: (please place an "X" next to any procedures or surgeries that you have had in the past)

- ☐ NEVER HAD ANY SURGERY
- ☐ Abdominal aortic aneurysm repair
- ☐ CABG/coronary artery bypass surgery
- ☐ Cardiac ablation
- ☐ Cardiac catheterization
- ☐ Cardioversion
- ☐ Carotid endarterectomy
- ☐ Femoral-popliteal bypass
- ☐ ICD
- ☐ Pacemaker
- ☐ PTA/angioplasty of an artery
- ☐ PTCA/stent of coronary artery
- ☐ Thoracic aortic aneurysm repair
- ☐ Valve surgery/repair/replacement
- ☐ Vascular surgery

- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery
- ☐ Brain surgery
- ☐ Carpal tunnel surgery
- ☐ Cataract Removal
- ☐ Caesarian Section
- ☐ Cholecystectomy/gallbladder
- ☐ Colon surgery
- ☐ Hip surgery
- ☐ Hysterectomy
- ☐ Inguinal hernia repair
- ☐ Kidney removal
- ☐ Knee arthroscopy
- ☐ Knee replacement
- ☐ Neck surgery
- ☐ Orthopedic (type: ____________________)
- ☐ Prostate surgery
- ☐ Shoulder surgery
- ☐ Sinus surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation (females)
- ☐ Vasectomy
- ☐ Ventral hernia repair
- ☐ Other: ______________________

Family History

	Alive/Deceased	No health problems	Arrhythmias	Cancer	Coronary artery disease	Clotting disorders	Fainting	Heart attack	Heart disease	Heart failure	Hyperlipidemia	Hypertension	Sudden death	Other
Mother														
Father														
Sister														
Sister														
Sister														
Brother														
Brother														
Brother														

A = alive D = deceased

☐ Adopted ☐ Family history unknown

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Alcohol Use:
❑ No
❑ Not currently
❑ Yes (___ glasses of wine/week; ___ cans of beer/week; ___ shots of liquor/week)
❑ How many drinks containing alcohol do you have on a typical day when you are drinking? _____
❑ How often do you have six or more drinks on one occasion? _____

Sexual Activity
❑ Yes
❑ Not Currently
❑ Never
❑ Birth Control/Protection _______________

Substance Use/Drug Use: ❑ No ❑ Yes (type: ______________)

Tobacco use
❑ Never smoked ❑ Current every day smoker (___ packs/day for ___ years)
❑ Prior smoker (___ packs/day for ___ years; quit _____)
❑ Smokeless Tobacco; Type: ❑ Snuff ❑ Chew

Occupation: ❑ Employed; occupation: ____________________ ❑ Unemployed ❑ Disabled ❑ Retired

Marital status: ❑ Single ❑ Married ❑ Legally separated ❑ Divorced ❑ Widowed ❑ Significant other

Primary Language: ❑ English ❑ Spanish ❑ Other: ____________________

Ethnic group: ❑ Non-Hispanic ❑ Hispanic or Latin

Race: ❑ White or Caucasian ❑ Black or African American ❑ Asian
❑ American Indian or Alaska native ❑ Native Hawaiian or Pacific Islander ❑ Some other race

Is there anything else that you think the physician should be aware of?

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CVC - Comprehensive Review of Systems

General
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Chronic pain
- ☐ Daytime sleepiness
- ☐ Diaphoresis (abnormally increased sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Generalized weakness
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Weight change unexpected
- ☐ NONE OF THE ABOVE

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia (excessive thirst)
- ☐ Polyphagia (excessive hunger)
- ☐ Polyuria (production of abnormally large volumes of dilute urine)
- ☐ NONE OF THE ABOVE

Allergy/Immunology
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Immunocompromised
- ☐ Recurrent infections
- ☐ Urticaria (hives)
- ☐ NONE OF THE ABOVE

Heme/Lymph
- ☐ Adenopathy (enlargement of lymph nodes)
- ☐ Bleeding too easily
- ☐ Bruising too easily
- ☐ NONE OF THE ABOVE

Psychiatric
- ☐ Agitation
- ☐ Anxious/nervous
- ☐ Behavior problem
- ☐ Confusion
- ☐ Depressed mood
- ☐ Hallucinations (perception in the absence of external stimulus)
- ☐ High stress level
- ☐ Hyperactive
- ☐ Injury to self
- ☐ Memory loss
- ☐ Sleep problems
- ☐ Suicidal thoughts
- ☐ Trouble concentrating
- ☐ Violent thoughts
- ☐ NONE OF THE ABOVE

Head & Neck
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Tinnitus (ringing in the ears)
- ☐ Vertigo (sensation of feeling off balance)
- ☐ Congestion
- ☐ Epistaxis (nose bleeds)
- ☐ Post-nasal drip
- ☐ Rhinorrhea (runny nose)
- ☐ Sinus pain
- ☐ Sneezing
- ☐ Snoring
- ☐ Dental problem
- ☐ Mouth sores
- ☐ Sore throat
- ☐ Choking
- ☐ Hoarse voice
- ☐ Nuchal stiffness (discomfort with turning neck)
- ☐ NONE OF THE ABOVE

Eyes
- ☐ Discharge
- ☐ Itching
- ☐ Pain
- ☐ Redness
- ☐ Blurriness
- ☐ Diplopia (double vision)
- ☐ Halos
- ☐ Photophobia (discomfort or pain to the eyes due to light exposure)
- ☐ Loss of vision
- ☐ Other vision disturbance
- ☐ NONE OF THE ABOVE

Neurological
- ☐ Balance issues
- ☐ Coordination issues
- ☐ Dizziness
- ☐ Dysphasia (difficulty swallowing)
- ☐ Facial asymmetry
- ☐ Focal weakness
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Paralysis
- ☐ Paresthesias (tingling or pricking)

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- ☐ Seizures
- ☐ Syncope
- ☐ Tremors
- ☐ NONE OF THE ABOVE

Respiratory
- ☐ Cough
- ☐ Dyspnea
- ☐ Hemoptysis (cough up blood)
- ☐ Sleep apnea
- ☐ Sputum
- ☐ Tightness across chest
- ☐ Wheezing
- ☐ NONE OF THE ABOVE

Cardiovascular
- ☐ Chest pain
- ☐ Dyspnea on exertion (difficulty breathing when engaged in a simple activity like walking)
- ☐ Near syncope (almost having a loss of consciousness)
- ☐ Orthopnea (shortness of breath that occurs when lying flat)
- ☐ Palpitations
- ☐ PND (severe shortness of breath and coughing that generally occur at night)
- ☐ Claudication (cramping pain in the leg which is induced by exercise)
- ☐ Cyanosis (bluish discoloration, especially of the skin and mucous membranes)
- ☐ Leg swelling
- ☐ NONE OF THE ABOVE

Skin
- ☐ Abnormal color change
- ☐ Dryness
- ☐ Flushing
- ☐ Hair change
- ☐ Itching
- ☐ Nail changes
- ☐ Rash
- ☐ Skin lesion
- ☐ Subcutaneous nodule
- ☐ Wound healing issues
- ☐ NONE OF THE ABOVE

Musculoskeletal
- ☐ Arthralgia (joint pain)
- ☐ Back pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Myalgias (muscle pain)
- ☐ Neck pain
- ☐ Stiff joints
- ☐ NONE OF THE ABOVE

Breast
- ☐ Breast lump or mass
- ☐ Discharge
- ☐ Skin change
- ☐ NONE OF THE ABOVE

Gastrointestinal
- ☐ Acid reflux
- ☐ Swallowing problems
- ☐ Abdominal pain
- ☐ Anorexia (lack or loss of appetite for food)
- ☐ Bloating
- ☐ Bright red hematemesis (blood in vomitus)
- ☐ Coffee group hematemesis (blood in vomitus)
- ☐ Early satiety (unable to eat a full meal)
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel habit change
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fecal incontinence
- ☐ Flatulence
- ☐ Hematochezia (blood in stool)
- ☐ Melena (black, tarry stool)
- ☐ Rectal bleeding
- ☐ Rectal pain
- ☐ NONE OF THE ABOVE

Genitourinary
- ☐ Dysuria (pain or discomfort when urinating)
- ☐ Enuresis (involuntary urination)
- ☐ Flank pain
- ☐ Frequency
- ☐ Hematuria (blood inurine)
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Nocturia (getting up to urinate at night)
- ☐ Reduced urine output
- ☐ Retention
- ☐ Urgency
- ☐ Decreased libido (reduced sex drive)
- ☐ Dyspareunia (painful intercourse)
- ☐ Genital lesion
- ☐ Pelvic pain
- ☐ Postcoital bleeding
- ☐ NONE OF THE ABOVE

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