SOUTHWEST
Cardiothoracic Surgeons

# CARDIOTHORACIC
# NEW PATIENT HEALTH HISTORY

**GRAY SHADED AREAS ARE FOR OFFICE USE**

Date of Visit: ______________________________ Account Number: __________

Last Name: __________________ First Name: ____________ MI: _____

Date of Birth: __________________ Age: ___ Sex: M/F SS#: ________________

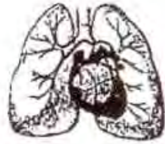
Primary Care Physician: __________________ Requesting Physician: ____________

Reason for Office Visit Today: ________________________________________

**HISTORY OF PRESENT ILLNESS** **FOR OFFICE USE ONLY**

**PAST MEDICAL HISTORY: (i.e. diabetes, high blood pressure...)**

| Diagnosis | Year Diagnosed |
| --- | --- |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |



SOUTHWEST
Cardiothoracic Surgeons

Do you have any of the following already prepared?

- ☐ Yes ☐ No Advanced Directives (Living Will)
- ☐ Yes ☐ No Durable Power of Attorney for Health Care
- ☐ Yes ☐ No Organ Donation
- ☐ Yes ☐ No Mental Health Directives

PAST SURGICAL HISTORY:

Please list any previous surgeries/procedures and approximate year below.

| Surgical Procedure | Year |
|---|---|
| 1 ______________________ | ________ |
| 2 ______________________ | ________ |
| 3 ______________________ | ________ |
| 4 ______________________ | ________ |
| 5 ______________________ | ________ |
| 6 ______________________ | ________ |
| 7 ______________________ | ________ |
| 8 ______________________ | ________ |
| 9 ______________________ | ________ |

Have you ever been hospitalized for any reason besides surgery: ☐ Yes ☐ No
If yes, reason and date: ______________________

Do you have any physical limitations? ☐ Yes ☐ No
If yes, please explain: ______________________

Have you ever had a blood transfusion: ☐ Yes ☐ No
If yes, when? ______________________ Adverse reaction? ☐ Yes ☐ No

Do you consent to the use of blood or blood products if necessary? ☐ Yes ☐ No
If no, please list religious or person reason______________________

My Medicine List

Speak UP™

## LIST ALL OF YOUR:

- Prescription Medicines
- Vitamins
- Diet Supplements
- Recreational Drugs
- Over the Counters (Example: Aspirin)
- Herbs
- Natural Remedies
- Amount of Alcohol you drink per day or week

It's important to include all of this information in case of an emergency.

List the amount that you usually take and how often or what time of day you take it.

Please feel free to take a medication card - keep it with you and keep it current.

Share it with your pharmacist, doctor and other caregivers.

## WE ENCOURAGE YOU TO SPEAK UP™:

Speak up if you have questions or concerns, and if you still don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you get. Always make sure you're getting the right treatments and medicines by the right health care professionals. Don't assume anything.

Educate yourself about your illness. Learn about the medical tests you get, and your treatment plan.

Ask a trusted family member or friend to be your advocate (advisor or supporter).

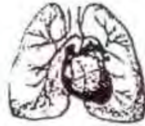
Know what medicines you take and why you take them. Medicine errors are the most common health care mistakes.

Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully checked out. For example, The Joint Commission visits hospitals to see if they are meeting The Joint Commission's quality standards.

Participate in all decisions about your treatment. You are the center of the health care team.

**The goal of the Speak Up™ program is to help patients become more informed and involved in their health care.**

The Joint Commission



SOUTHWEST
Cardiothoracic Surgeons

## ALLERGIES:

Please list all medications to which you have an allergy or an adverse response and the corresponding reaction

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## CURRENT MEDICATIONS:

Please list all medications (prescription and non-prescriptions), including vitamins, aspirin, herbs and /or appetite suppressants.

| Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

SOUTHWEST
Cardiothoracic Surgeons

## SOCIAL HISTORY

Martial Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Number of children: ____________________

Current hometown: ____________________

With whom do you live? ____________________

Who is at home to take care of you following surgery, or will you be residing elsewhere?
Please explain: ____________________

Current (or previous) occupation: ____________________
Are you retired? ☐ Yes ☐ No

How stressful is your job? ☐ None ☐ Mildly ☐ Moderately ☐ Very

List any hobbies: ____________________

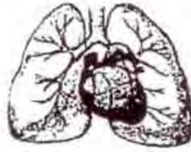
*Do you exercise?* ☐ Yes ☐ No
If yes, describe how and how often: ____________________

*Do you smoke?* ☐ Yes ☐ No, but use to ☐ Never smoked
How many packs of cigarettes do/did you smoke per day? ____________________
How many years have you smoked? ____________________
When did you quit? ____________________

*Do you drink alcohol?* ☐ Yes ☐ No, but use to ☐ Never drank
How much of the following did/do you drink in an average week?
______ glasses of wine ______ beers ______ drinks
When did you quit? ____________________

*Do you consume caffeine?* ☐ Yes ☐ No, but used to ☐ Never
When did you quit? ____________________
How much in an average day do you consume of the following:
______ Sodas ______ Cups of Coffee ______ Glasses of Tea

*Do you take illicit drugs or abuse prescription medications?*
☐ Yes ☐ No, but used to ☐ Never
If yes, please specify: ____________________

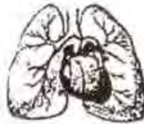


SOUTHWEST
Cardiothoracic Surgeons

## FAMILY HISTORY

*Please place a "X" in any box that applies to you.*

| ***ILLNESS*** | Father | Mother | Brother | Sister | Grand Father | Grand Mother | Son(s) | Daughter(s) |
|---|---|---|---|---|---|---|---|---|
| LIVING | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Age | | | | | | | | |
| High Blood | | | | | | | | |
| Pressure | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Attack | | | | | | | | |
| Other Heart Disease | | | | | | | | |
| Lung Cancer | | | | | | | | |
| Esophageal Cancer | | | | | | | | |
| Esophageal Disease | | | | | | | | |
| Breast Cancer | | | | | | | | |
| Other Cancer (please specify) | | | | | | | | |
| Blood or clotting disorder | | | | | | | | |
| Stroke | | | | | | | | |
| Sudden Death | | | | | | | | |



SOUTHWEST
Cardiothoracic Surgeons

**REVIEW OF SYSTEMS**

Please check all that apply and indicate the date the condition started.

### *I. General System Review*

| Yes | No | Condition | Date |
|---|---|---|---|
| ☐ Yes | ☐ No | Unintentional weight loss | ______ |
| ☐ Yes | ☐ No | Fever | ______ |
| ☐ Yes | ☐ No | Chills | ______ |
| ☐ Yes | ☐ No | Sweats | ______ |
| ☐ Yes | ☐ No | Fatigue | ______ |

### *II. Lung System Review*

| Yes | No | Condition | Date |
|---|---|---|---|
| ☐ Yes | ☐ No | Chronic cough | ______ |
| ☐ Yes | ☐ No | New cough | ______ |
| ☐ Yes | ☐ No | Sputum production | ______ |
| ☐ Yes | ☐ No | Hemoptysis (coughing blood) | ______ |
| ☐ Yes | ☐ No | Hoarseness | ______ |
| ☐ Yes | ☐ No | Asthma | ______ |
| ☐ Yes | ☐ No | Wheezing | ______ |
| ☐ Yes | ☐ No | Shortness of breath at rest | ______ |
| ☐ Yes | ☐ No | Shortness of breath with activity | ______ |
| ☐ Yes | ☐ No | Bronchitis | ______ |
| ☐ Yes | ☐ No | Pneumonia | ______ |
| ☐ Yes | ☐ No | Sleep Apnea | ______ |
| ☐ Yes | ☐ No | Snoring | ______ |
| ☐ Yes | ☐ No | Tuberculosis | ______ |

### *III. Previous Pulmonary Testing*

| Yes | No | Test | Date/Location |
|---|---|---|---|
| ☐ Yes | ☐ No | Chest x-ray | Date/Location ______ |
| ☐ Yes | ☐ No | CT scan | Date/Location ______ |
| ☐ Yes | ☐ No | PET scan | Date/Location ______ |
| ☐ Yes | ☐ No | Needle Biopsy | Date/Location ______ |
| ☐ Yes | ☐ No | Pulmonary function tests | Date/Location ______ |
| ☐ Yes | ☐ No | Bronchoscopy | Date/Location ______ |
| ☐ Yes | ☐ No | Tissue biopsy | Date/Location ______ |

## IV. Cardiovascular System Review

| | | Condition | Date |
|---|---|---|---|
| [ ] Yes | [ ] No | Diabetes (insulin Dependent: Yes No | |
| [ ] Yes | [ ] No | High blood pressure | |
| [ ] Yes | [ ] No | High cholesterol | |
| [ ] Yes | [ ] No | History of weight loss medicine (i.e. phen/fen) | |
| [ ] Yes | [ ] No | Rheumatic/scarlet fever | |
| [ ] Yes | [ ] No | Heart murmur | |
| [ ] Yes | [ ] No | Chest Pain | |
| [ ] Yes | [ ] No | Shortness of breath | |
| [ ] Yes | [ ] No | Coronary artery disease | |
| [ ] Yes | [ ] No | Heart attack | |
| [ ] Yes | [ ] No | Abnormal EKG | |
| [ ] Yes | [ ] No | Arrhythmia (abnormal heart rhythm) | |
| [ ] Yes | [ ] No | Hospitalized for cardiac reasons | |
| [ ] Yes | [ ] No | Any other type of heart disease | |

## V. Previous Cardiovascular Testing

| | | | | |
|---|---|---|---|---|
| [ ] Yes | [ ] No | Stress Test | Date ______ | Location ______ |
| [ ] Yes | [ ] No | Echocardiogram | Date ______ | Location ______ |
| [ ] Yes | [ ] No | Nuclear study | Date ______ | Location ______ |
| [ ] Yes | [ ] No | Holter | Date ______ | Location ______ |
| [ ] Yes | [ ] No | Carotid ultrasound | Date ______ | Location ______ |
| [ ] Yes | [ ] No | Catheterization/Angiogram | Date ______ | Location ______ |
| [ ] Yes | [ ] No | Electrophysiology study | Date ______ | Location ______ |
| [ ] Yes | [ ] No | CT Angiogram | Date ______ | Location ______ |

## VI. Vascular System Review

| | | | |
|---|---|---|---|
| [ ] Yes | [ ] No | Carotid artery disease | ______ |
| [ ] Yes | [ ] No | Renal artery disease | ______ |
| [ ] Yes | [ ] No | Peripheral artery disease (poor leg circulation) | ______ |
| [ ] Yes | [ ] No | History of aneurysm | ______ |
| [ ] Yes | [ ] No | Claudication (cramping in legs while walking) | ______ |
| [ ] Yes | [ ] No | Phlebitis (cloths in legs) | ______ |
| [ ] Yes | [ ] No | Pulmonary embolism (clots in lungs) | ______ |
| [ ] Yes | [ ] No | Any other type of vascular disease | ______ |

## *VII. Gastrointestinal System Review*

| | | | Date |
|---|---|---|---|
| ☐ Yes | ☐ No | Nausea/vomiting | ____________ |
| ☐ Yes | ☐ No | Loss of Appetite | ____________ |
| ☐ Yes | ☐ No | Reflux (heartburn) | ____________ |
| ☐ Yes | ☐ No | Trouble swallowing liquids | ____________ |
| ☐ Yes | ☐ No | Trouble swallowing solids | ____________ |
| ☐ Yes | ☐ No | Abdominal pain | ____________ |
| ☐ Yes | ☐ No | Constipation | ____________ |
| ☐ Yes | ☐ No | Diarrhea | ____________ |
| ☐ Yes | ☐ No | Blood in stools | ____________ |
| ☐ Yes | ☐ No | Esophageal disease | ____________ |

## *VIII. Gastrointestinal Testing*

| | | | |
|---|---|---|---|
| ☐ Yes | ☐ No | Upper/Lower endoscopy (EGD/Colonoscopy) | ____________ |
| ☐ Yes | ☐ No | Biopsy | ____________ |
| ☐ Yes | ☐ No | Swallowing studies | ____________ |

**THE FOLLOWING QUESTION SRELATE TO HEALTH PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST. (Please circle the appropriate conditions)**

| | | |
|---|---|---|
| ☐ Yes | ☐ No | Endocrine/hormonal (thyroid disease, adrenal disease, goiter) |
| ☐ Yes | ☐ No | Neurological (seizures, vertigo, previous stroke, aneurysm, etc) |
| ☐ Yes | ☐ No | Ophthalmologic (glaucoma, cataracts, visual impairment, etc) |
| ☐ Yes | ☐ No | Ear, nose, throat (snoring, hearing aids, sinus, hoarseness, nose |
| ☐ Yes | ☐ No | bleeds, etc) |
| ☐ Yes | ☐ No | Renal/kidney (renal insufficiency, dialysis, kidney stones, etc) |
| ☐ Yes | ☐ No | Urological (prostate disease, frequent bladder infections, |
| ☐ Yes | ☐ No | impotence, etc) |
| ☐ Yes | ☐ No | Immunological (gout, rheumatoid arthritis, lupus, etc) |
| ☐ Yes | ☐ No | Infectious (aids, hepatitis, TB, syphilis, endocarditis, etc) |
| ☐ Yes | ☐ No | Hematologic (anemia, bleeding/clotting problems, leukemia etc) |
| ☐ Yes | ☐ No | Psychological (depression, anxiety, panic attacks, anorexia, bulimia, etc) |
| ☐ Yes | ☐ No | Physical disability (problems with walking, etc) |
| ☐ Yes | ☐ No | Skin (psoriasis, eczema, petichiae, etc) |
| ☐ Yes | ☐ No | Vascular (varicose veins, aortic aneurysm, etc) |
| ☐ Yes | ☐ No | Musculoskeletal (joint pain, arthritis, weakness etc) |

I have reviewed the above information with the patient:

______________________________________________ (PA)

______________________________________________ (M.D.)

____________________ Date