Cardiovascular Surgery of Southern Nevada

History & Physical

(Confidential)

ALLERGIES (MEDICAL & OTHER)

Name ______________________________ Today's Date ______________________

Age ____________ Birth Date ____________________ Date of last physical examination ____________

Reason for Visit / Chief Complaint ____

____

PAST MEDICAL/SURGICAL HISTORY

Do you have or have had: (please check all that apply)

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Cardiovascular
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Gastrointestinal
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Eye, Ear, Nose, Throat
- ☐ Blurred Vision
- ☐ Vision - Flashes
- ☐ Vision - Halos
- ☐ Double Vision
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Persistent Cough
- ☐ Earache
- ☐ Ear Discharge
- ☐ Loss of Hearing
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Sinus Problems

Skin
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men only
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on penis
- ☐ Other ____________

Muscle/Joint/Bone

Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Women only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other ____________

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

Conditions (please check any you have or had in the past)

- ☐ AIDS
- ☐ HIV Positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Other ____________

____

____

Name ______________________________ Today's Date ____________________________

Birth Date ______________________________

Medications & Dosage	Directions

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates: ____

Family History (include diabetes, hypertension, stroke, aneurysm, varicose veins, amputation)		
Relation	Current Age/Serious Illnesses	Age at Death/Cause of Death
Father		
Mother		
Brothers		
Sisters		

Surgery/Hospitalization/Serious Illness		
Year	Illness/Procedure	Complications

Social History (please check and indicate usage)

☐ Caffeine ______________________________
☐ Tobacco ______________________________
☐ Drugs ______________________________
☐ Alcohol ______________________________
☐ Other ______________________________

Patient's Signature ____ Date ________________

Physician's Signature ____ Date ________________

Revised 7.30.2018