Name: _____ DOB: _____ Acct. #: _____ Date: _____

LEXINGTON HEART SPECIALISTS

Cardiovascular:

	Yes	No
Poor circulation	☐	☐
High blood pressure	☐	☐
Aortic Aneurysm	☐	☐
Heart disease	☐	☐
Vascular disease	☐	☐
Heart attack	☐	☐
Chest pain	☐	☐
High cholesterol	☐	☐
Pacemaker	☐	☐
Jaw pain	☐	☐
Irregular heartbeat	☐	☐
Swelling of legs	☐	☐
Palpitations	☐	☐
Murmur	☐	☐

Genitourinary:

	Yes	No
Kidney disease	☐	☐
Frequent urination	☐	☐
Blood and urine	☐	☐
Kidney stone	☐	☐
Kidney Failure	☐	☐
Dialysis	☐	☐
Prostate	☐	☐

Hematologic / Lymphatic:

	Yes	No
Hepatitis	☐	☐
Blood clots	☐	☐
Cancer	☐	☐
Easy bruising	☐	☐
Easy bleeding	☐	☐
Fever / Chills / Sweats	☐	☐

Respiratory:

	Yes	No
Asthma	☐	☐
Tuberculosis	☐	☐
Shortness of breath	☐	☐
Emphysema	☐	☐
Cold / Flu	☐	☐
Cough / Wheezing	☐	☐
Pneumonia	☐	☐
Black Lung Disease	☐	☐
COPD	☐	☐

Ear / Nose / Throat:

	Yes	No
Dizziness	☐	☐
Hearing loss	☐	☐
Nosebleed	☐	☐
Difficulty swallowing	☐	☐
Ringing Noise in ears	☐	☐

Eyes:

	Yes	No
Glaucoma	☐	☐
Double vision	☐	☐
Blurred vision	☐	☐

Integumentary:

	Yes	No
Skin ulcers	☐	☐
Skin disease	☐	☐
Rashes	☐	☐

Allergic / Immunologic:

	Yes	No
Hives	☐	☐
Immune disorder	☐	☐
HIV / AIDS	☐	☐
Allergy shot	☐	☐

Gastrointestinal:

	Yes	No
Bowel problems	☐	☐
Ulcers	☐	☐
Diarrhea	☐	☐
Nausea / Vomiting	☐	☐
Poor appetite	☐	☐
Hiatal Hernia	☐	☐
Gall Stones	☐	☐
Pancreatitis	☐	☐

Musculoskeletal:

	Yes	No
Gout	☐	☐
Arthritis	☐	☐
Joint stiffness	☐	☐
Muscle weakness	☐	☐
Osteoporosis	☐	☐
Legs Hurt when walk	☐	☐

Neurological:

	Yes	No
Stroke	☐	☐
Seizures	☐	☐
Head injury	☐	☐
Brain aneurysm	☐	☐
Numbness	☐	☐
Severe headaches	☐	☐
Parkinson's disease	☐	☐
Standing / Balance	☐	☐

Endocrine:

	Yes	No
Thyroid disease	☐	☐
Diabetes	☐	☐
Menopausal	☐	☐

Psychiatric:

	Yes	No
Depression	☐	☐
Anxiety disorder	☐	☐
Unusual stress	☐	☐
Dementia	☐	☐

Constitutional:

	Yes	No
Weight loss / gain	☐	☐
Energy level problems	☐	☐
Difficulty sleeping	☐	☐

Past Surgeries / Procedures

Stent Placement:	Coronary Or Peripheral	
Valve Replacement:	☐ Yes	☐ No
Valve Repair:	☐ Yes	☐ No
Aneurysm Surgery:	☐ Yes	☐ No
Angioplasty:	☐ Yes	☐ No
Bypass Surgery:	☐ Yes	☐ No
Carotid Artery Surgery:	☐ Yes	☐ No
Pacemaker:	☐ Yes	☐ No
ICD / Defibrillator:	☐ Yes	☐ No
Other Surgeries:	☐ Yes	☐ No

_____

_____

Social History

Single Married Divorced Widow

Children # _____

Education: _____

Occupation: _____

Retired ____ Disabled ____ Date: _____

Tobacco: Chew: ☐ Yes ☐ No

Smoke: ☐ Yes ☐ No

# of Packs / Day _____

Coffee: # of Cups / Day _____

Caffeinated Soda: # _____

Alcohol: _____

Recreational Drug Use: ☐ Yes ☐ No

If yes, please list: _____

_____

Family History

Heart Attack:
Mother Father Brother Sister

Chest Pain / Angina:
Mother Father Brother Sister

Bypass Surgery:
Mother Father Brother Sister

Valve Surgery:
Mother Father Brother Sister

Stent Placement:
Mother Father Brother Sister

Pacemaker:
Mother Father Brother Sister

ICD / Defibrillator:
Mother Father Brother Sister

Abnormal Heart Beat:
Mother Father Brother Sister

High Blood Pressure:
Mother Father Brother Sister

Strokes:
Mother Father Brother Sister

Diabetic:
Mother Father Brother Sister

Other:

_____

_____

_____