Central Nebraska
CARDIOLOGY
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Phone: 308.865.2601

Name ______________________ Date __________ Referring Dr. ____________________
Please help us find out about you by filling out the "Patient" side of this form.
Please leave the "Clinician" side blank   DOB: AGE:

PATIENT	CLINICIAN
Why are you here to see a cardiologist? ______________________	CC:
Can you tell us more about the above mentioned complaint?	HPI:

- ☐ CHEST DISCOMFORT
  - ☐ Description (dull, sharp, pressure, tightness, ache, burning, heaviness)
  - ☐ Location (chest, neck, arms, back, jaw, abdomen)
  - ☐ Does it radiate anywhere (arms, neck, throat, jaw, back)?
  - ☐ Do you have any other symptoms with this (shortness of breath, nausea and/or vomiting, or sweating)?
  - ☐ What activities is this associated with?
  - ☐ What relieves it?
  - ☐ How often does it occur?
  - ☐ How long does it last?
  - ☐ Have you ever had a
    - ○ Heart Attack? Date:
    - ○ Angina / Chest Pain?
- ☐ ARE YOU SHORT OF BREATH?
  - ☐ What makes you short of breath?
  - ☐ Are you short of breath getting around the house?
- ☐ DO YOU EXPERIENCE ANY LIGHTHEADEDNESS, DIZZINESS OR PASSING OUT SPELLS?
- ☐ HAVE YOU HAD ANY OF THE FOLLOWING
  - ☐ Irregular heartbeats or palpitations?
  - ☐ Abnormal heart rhythm (arrhythmia)?
- ☐ HAVE YOU EVER HAD
  - ☐ Ankle swelling?
  - ☐ An enlarged heart?
  - ☐ Heart failure?
  - ☐ Heart murmur?
  - ☐ Rheumatic fever?
  - ☐ Blue lips or fingernails?
  - ☐ Leg cramps when you walk?

Do you have any of the following risk factors for heart disease:

- ☐ High blood pressure
- ☐ Diabetes Mellitus
- ☐ High Cholesterol
- ☐ Tobacco Use
- ☐ Any family members with heart disease?

Have you ever had:

- ☐ A Stress Test
- ☐ An Echocardiogram
- ☐ Cardiac Catheterization/Heart Catheterization
- ☐ Coronary Angioplasty (balloon)
- ☐ Coronary Bypass Surgery
- ☐ Valve Surgery
- ☐ An Electrophysiology Study or Procedure
- ☐ A Pacemaker or Defibrillator

If you are a woman, have you passed menopause
(change of life)? ____________________
At what age? ____________________
Do you take estrogen replacement? __________   HPI (Circle):   Brief   Extended

PATIENT NAME: CLINICIAN:

Are you being treated now or have you been treated for any illness? Please list them:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

PPSH

Past Med Hx

Have you had any operations? Any injuries?

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Past Surg Hx

Marital Status: S M W D

Social History

With whom do you live? ______________________

Occupation ______________________

Leisure Activities ______________________

____

Education Level ______________________

Health Habits:

Have you ever smoked? ______________________

How many packs per day? ______________________

For how many years? ______ Year quit? ______

How much alcohol do you drink? ______________________

Do you use any drugs? ______________________

How much caffeine? ______________________

Do you exercise? ______________________

Check if any close family members (parents, brothers, and sisters, children) have:

Family History

- ☐ Heart problems: ______________________
- ☐ High Blood Pressure: ______________________
- ☐ Diabetes: ______________________
- ☐ Cancer: ______________________

Other Problems:

Are you allergic to any medications?

List medication to which you are allergic:

Allergies

PATIENT NAME:	CLINICIAN:

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications:

Medicines

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

Please circle any symptom you have, so we can find out more about it:

ROS

Symptoms	ROS
Lack of energy, trouble sleeping, loss of appetite, weight changes, fevers	Constitutional
Eye problems, such as double or blurred vision, glaucoma, cataracts	HEENT
Hearing problems, buzzing or ringing in the ears	
Allergies, hay fever, latex allergy	
Sinus problems	
Breathing problems, wheezing, cough, coughing blood Asthma, tuberculosis, COPD, emphysema, blood clot in the lung	Respiratory
Stomach problems, indigestion, change in bowel habits Bloody or tarry stools, jaundice, liver problems, ulcers, gallstones, difficulty swallowing, hiatal hernia, food sticking in throat	Digestive
Urinary problems: frequency, infections, stones, blood Bladder: urinary frequency, night time urination Men: Prostate problems Women: abnormal menstrual periods. Could you be pregnant?	Urinary
Joint pains, swelling or redness, arthritis, back pain Muscle aches or tenderness, gout, blood clots in legs	Musculoskeletal
Rash, itching or other skin problems	Dermatological
Women: breast lumps, recent mammogram, pap smear and/or pelvic exam	Female Reproductive
Paralysis (even temporary), stroke, numbness, loss of balance	Neurological
Seizures, loss of memory, headaches	
Unusual thoughts, nervousness, crying or sadness, depression	
Suicide attempts	Psychiatric
Thyroid disorder, diabetes, excess thirst, hunger or urination	Endocrinology
Bleeding, easy bruising, risk factors for HIV, anemia, cancer	Hematological