Central Nebraska CARDIOLOGY

3219 Central Avenue, Suite 111
Kearney, NE 68847
Phone: 308-865-2601

Name: _____ Date: _____ Referring Dr.: _____

Primary Dr.: _____ DOB: _____ Age: _____

Please help us find out about you by filling out the "Patient" side of this form.
Please leave the "Clinician" side blank.

PATIENT	CLINICIAN

Why are you here to see a cardiologist? CC:

_____

Can you tell us more about the above-mentioned complaint? HPI:

- ☐ Have you ever had a Heart Attack? **YES or NO** Date_____
- ☐ Do you have Angina, Chest Pain, or 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 Shortness of Breath?
- ☐ What activities is this associated with?
  - What relieves it?
  - How often does it occur?
  - How long does it last?
- ☐ Do you have dizziness/feel lightheaded, pass out, irregular heartbeats, palpitations? (Circle all that apply)
- ☐ Do you use a CPAP?? **Yes or No**
- ☐ HAVE YOU EVER HAD
  - Abnormal heart rhythm? A-Fib
  - 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 risks for heart disease?
  - High blood pressure
  - Diabetes Mellitus
  - High Cholesterol
  - Tobacco Use
  - Any Family Members with Heart disease? **Yes or No**
- ☐ 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? Brand: _____
- ☐ If you are a woman, have you passed menopause? **Yes or No**
  - At what age? _____
  - Do you take an estrogen replacement? _____

HPI (Circle): Brief Extended

Past Medical History:

Have you ever been **diagnosed** with any of the following conditions or had any procedures listed below? *Check Yes or No. If yes, please give an explanation.*

SYSTEMS	PATIENT COMMENTS	PHYSICIAN COMMENTS
CARDIOVASCULAR HISTORY		
Atrial Fibrillation……..	☐**YES** ☐**NO**	
Blood Clotting Disorder……	☐**YES** ☐**NO**	
Carotid Artery Disorder……	☐**YES** ☐**NO**	
Congestive Heart Failure……..	☐**YES** ☐**NO**	
Elevated Cholesterol……..	☐**YES** ☐**NO Level____ Date_____**	
Heart Murmur……	☐**YES** ☐**NO**	
Heart Surgery/Angioplasty……	☐**YES** ☐**NO**	
High Blood Pressure……..	☐**YES** ☐**NO**	
Prosthetic/Artificial Heart Valve……..	☐**YES** ☐**NO**	
Blockage of Arm or Leg Blood Vessels…	☐**YES** ☐**NO**	
Endocarditis……..	☐**YES** ☐**NO**	
Diabetes…….	☐**YES** ☐**NO**	
Thyroid Disease…….	☐**YES** ☐**NO**	
Blood Clot in Lung……	☐**YES** ☐**NO**	
OTHER HEALTH HISTORY		
Stomach Ulcers……..	☐**YES** ☐**NO**	
Liver Disease/Hepatitis……	☐**YES** ☐**NO**	
Kidney/Bladder Disease……	☐**YES** ☐**NO**	
Lung Disease…….	☐**YES** ☐**NO**	
Tuberculosis/COPD/Asthma……..…..	☐**YES** ☐**NO**	
MRSA Infection……	☐**YES** ☐**NO**	
Alcohol Dependency…….	☐**YES** ☐**NO**	
Cancer……	☐**YES** ☐**NO**	
Drug Abuse……	☐**YES** ☐**NO**	
Immune System Disorder……..	☐**YES** ☐**NO**	
Toxic Exposure……..	☐**YES** ☐**NO**	
Sexually Transmitted Disease……...	☐**YES** ☐**NO**	

Other Medical Problems: (Please list all medical conditions not listed above.):

_____

_____

_____

Surgical History/Previous Operations/Hospitalizations: (Please use back of page if more room is needed.)

Date:	Hospital	Problem/Operation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications:

Please list any medications (Prescription and Over the Counter) you are currently taking (including Vitamins and Aspirin). (Please use back of page if more room is needed.)

Medications	Dosage/Amount	How many times daily?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy History:

Have you ever had an allergic reaction to any medication? ☐**YES** ☐**NO** If yes, please list medication and **REACTION** below.

_____

Do you have a Latex Allergy? ☐**YES** ☐**NO** Do you have an allergy to IV Dye/Contrast? ☐**YES** ☐**NO**

Social History

Birthplace: _____ Highest Grade Completed in School: _____ Current Occupation: _____

Marital Status: ☐**Married** ☐**Single** ☐**Divorced** ☐**Widowed** Who currently lives at home with you? _____

Have you ever smoked cigarettes: ☐**YES** ☐**NO** Vape? ☐**YES** ☐**NO** Age Started Smoking? _____

If yes, how much do you currently smoke per day? _____ What year did you quit smoking? _____

Are you exposed to second hand smoke? ☐**YES** ☐**NO**

Do you chew tobacco? ☐**YES** ☐**NO** How much do you chew? _____ What brand do you chew? _____

Do you drink alcohol? ☐**YES** ☐**NO** Type_____ How often/much? _____

Do you use other drugs (i.e., marijuana, meth, cocaine, etc.)? ☐**YES** ☐**NO**

Do you drink caffeine (i.e., coffee or soda)? ☐**YES** ☐**NO**

Have you had significant exposure to: Toxins (Pesticides, Herbicides)? ☐**YES** ☐**NO**

Do you exercise? ☐**YES** ☐**NO** What kind of exercise? _____

Do you have any Dietary restrictions? ☐**YES** ☐**NO**

Family History:

Family Member	**Age (or age at death)**	**Sex**	**Living**	**Medical Problems**
Grandparents	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
Father	_____		☐YES ☐NO	_____
Mother	_____		☐YES ☐NO	_____
Siblings	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
Children	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____
	_____	☐ M ☐ F	☐YES ☐NO	_____

REVIEW OF SYSTEMS:

Have you experienced any of the following symptoms? Please check yes, or no. If yes, please give an explanation.

Clinician: Please check box of WNL or record abnormalities. Leave blank if not reviewed.

SYSTEM	**Patient: Responses**	**Patient Comments**	**Provider Comments**
CONSTITUTIONAL			☐**WNL**
Recent weight change…….	☐**YES** ☐**NO**		
Extreme Fatigue……..…..	☐**YES** ☐**NO**		
Loss of appetite……..……..	☐**YES** ☐**NO**		
Difficulty sleeping……..	☐**YES** ☐**NO**		
Fever/chills…….	☐**YES** ☐**NO**		
EYES			☐**WNL**
Wear glasses, contact lenses……...	☐**YES** ☐**NO**		
Change in vision…….	☐**YES** ☐**NO**		
Glaucoma…….	☐**YES** ☐**NO**		
EARS, NOSE, MOUTH THROAT			☐**WNL**
Change in hearing……...	☐**YES** ☐**NO**		
Ringing in the ears……..	☐**YES** ☐**NO**		

Recent nose bleeds…….	☐YES ☐NO		
Chronic sinus problems……..	☐YES ☐NO		
Voice changes……	☐YES ☐NO		
ALLERGY/IMMUNOLOGY			☐WNL
Environmental allergies……..	☐YES ☐NO		
RESPIRATORY			☐WNL
Breathing problems/shortness of breath……..	☐YES ☐NO		
Coughing up blood…….	☐YES ☐NO		
Chronic cough……	☐YES ☐NO		
GASTROINTESTIAL			☐WNL
Difficulty swallowing……..	☐YES ☐NO		
Heart burn……	☐YES ☐NO		
Frequent diarrhea……	☐YES ☐NO		
Constipation……	☐YES ☐NO		
Black or bloody stools……	☐YES ☐NO		
Abdominal pain……..	☐YES ☐NO		
Nausea/vomiting…….	☐YES ☐NO		
Vomiting blood/blood in stools……..	☐YES ☐NO		
GENITOURINARY			☐WNL
Blood in urine…….	☐YES ☐NO		
Burning w/ urination……..	☐YES ☐NO		
Difficult/frequent urination……	☐YES ☐NO		
Lack of bladder control……..	☐YES ☐NO		
Change in sexual function……..	☐YES ☐NO		
MUSCULOSKELETAL			☐WNL
Joint/muscle stiffness or pain…….	☐YES ☐NO		
Weakness of muscles or joints……..	☐YES ☐NO		
Back pain……	☐YES ☐NO		
Difficulty walking……..	☐YES ☐NO		
INTEGUMENTARY			☐WNL
Unusual or prolonged rashes……..	☐YES ☐NO		
Breast pain or lump……	☐YES ☐NO		
Change in hair or nails……	☐YES ☐NO		
NEUROLOGICAL			☐WNL
Headaches……..	☐YES ☐NO		
Numbness/tingling sensation……..	☐YES ☐NO		
Weakness or paralysis……	☐YES ☐NO		
Convulsions or seizures……..	☐YES ☐NO		
Change in memory/concentration…..	☐YES ☐NO		
Black-outs/dizziness……..	☐YES ☐NO		
Memory loss or confusion……..	☐YES ☐NO		
Other neurological problems……..	☐YES ☐NO		
PSYCHIATRIC			☐WNL
Nervousness……	☐YES ☐NO		
Depression……..	☐YES ☐NO		
Other……..	☐YES ☐NO		
ENDOCRINE			☐WNL
Thyroid problems……..	☐YES ☐NO		
Heat or cold intolerance…….	☐YES ☐NO		
Excess thirst or urination……	☐YES ☐NO		
HEMATOLOGY/LYMPHATIC			☐WNL
Easy bruising……..	☐YES ☐NO		
Bleeding Disorder……..	☐YES ☐NO		
Enlarged lymph nodes……	☐YES ☐NO		
HIV or Cancer……			