Middlesex Cardiology Associates, P.C.

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Date of Visit _____

PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name_____ First_____ Middle_____ Date of Birth_____

_____

Email address _____

Date of Last Physical Examination_____ Doctor _____

Family or Referring Physician _____

FAMILY HISTORY	SEX	IF LIVING		IF DECEASED	
		Age	Health	Age at Death	Cause
Father	M				
Mother	F				
Brothers/Sisters (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				

Since some names may be used for both men & women, please circle sex for each Brother, Sister, Son, or Daughter

Do you know of any blood relative who has or had: (Circle & give relationship)

Stroke	_____	Leukemia	_____	Arthritis	_____
Cancer	_____	Asthma	_____	Sudden Death	_____
High Blood Pressure	_____	Bleeding Tendency	_____	Rheumatic Heart	_____
Tuberculosis	_____	Heart Attack	_____	Congenital Heart	_____
Diabetes	_____	Kidney Disease	_____		

PERSONAL HISTORY

Do you, or have you ever smoked? YES NO

If yes(select which) cigarette pipe cigars

How much_____ How many years _____

If you have stopped, how long ago? _____

How much coffee or tea do you drink per day?_____

How much alcohol do you drink?_____

Do you have any allergies, including drugs? _____

Were you ever on oral contraceptives? YES NO

Do you take any medications YES NO

If yes, please list them _____ _____

_____ _____

_____ _____

_____ _____

Have you ever had any of the following (please circle)

Hypertension	Thyroid Problems	Diabetes	Emphysema
Gout or increased uric acid	Heart problems	Rheumatic fever	Increased cholesterol
Angina Pectoris			

Heart attack (date) _____ Heart Surgery (date) _____

Operations (dates) _____

Other _____

Please list previous hospitalizations and reasons:

_____

_____

_____

Have you ever had palpitations? YES NO

When did they first occur? _____

How long do they last? _____

Do you or have you ever had irregular heart beats or skipping? YES NO

When do you feel it? _____

What brings it on? _____

What relieves it? _____

Do you have "Discomfort" in any one or more of these areas? (circle)

Chest	Back	Shoulders	Arms	Neck
Jaw	Teeth	Upper Abdomen		

Type of discomfort? (circle)

Pressing	Squeezing	Constricting	Burning	Weight
Indigestion	Dull Ache	Vice like/Bank like	Other_____	

What brings the discomfort on? (circle)

Activity	Rest	Food	Sex	Coughing
Cold Weather	Emotional Stress	Lying in Bed	Walking against wind	

Other _____

What relieves the discomfort? (circle)

Rest	Walking	Food	Sitting Up	
Belching	Tranquilizer	Nitroglycerin	Other _____	

Have you ever used Nitroglycerin?	YES	NO
Do you take more than one Nitroglycerin to relieve it?	YES	NO
Do you have tenderness to touch in the areas of discomfort?	YES	NO
Have you ever had this discomfort at night, while in bed?	YES	NO
Did it ever wake you from sleep?	YES	NO
Have you ever had shortness of breath?	YES	NO

If yes, how long have you had it? _____

Do you have shortness of breath with any of the following activities?

While doing usual work?	YES	NO
Climbing a flight of stairs?	YES	NO
Walking uphill?	YES	NO
Does it awaken you at night?	YES	NO
Is this shortness of breath accompanied by a cough?	YES	NO

How many pillows do you sleep on? _____

Do you have an annoying cough?	YES	NO
If yes, for how long? _____		
What time of day or night do you get it? _____		
Is it a dry cough or productive? _____		
Have you ever coughed up blood?	YES	NO
Have you had wheezing with the cough?	YES	NO

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Anitha Yarlagadda, MD

Have you ever had swelling of the ankles? YES NO

If yes, how long have you had it? _____

Do you notice it in one or both ankles? _____

What time of day do you notice it the most? _____

Do you notice swelling after prolonged standing? _____

Do you have any of the following? (Please circle)

Dizziness Lightheadedness Fainting Near-fainting

Are any of these symptoms associated with the following (mark yes/no and circle which)

_____Palpitations
_____Anxiety/Emotional Stress
_____Hyperventilation
_____During, or immediately after exercise
_____In any particular body position (bending, leaning)
_____Before you eat
_____Dim vision, yawning, sweating, nausea, weakness of arms/legs, trouble speaking, unsteadiness
_____Sudden movement of the head, shaving the neck or wearing a tight collar

Have you had seizures? _____

Have you had the following symptoms?

Pain in the calves of your legs? YES NO

If yes, how long has this been happening?_____

When does it occur?_____

How far can you walk before getting pain?_____

Varicose veins? YES NO

Phlebitis and/or blood clot? YES NO

Have you had the following tests?

EKG Stress Test Angiogram Echocardiogram

Describe briefly your present medical symptoms:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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PATIENT PERSONAL HISTORY/REVIEW OF SYMPTOMS
(Please Circle)

NAME_____ DATE_____

CONSTITUTIONAL

FEVERS	Y	N
SWEATS	Y	N
WEIGHT GAIN	Y	N
INSOMNIA	Y	N
CHILLS	Y	N
WEIGHT LOSS	Y	N
FATIGUE	Y	N

EYES

WEAR GLASSES	Y	N
LOSS OF VISION	Y	N
GLAUCOMA	Y	N
BLURRED VISION	Y	N
BLIND SPOTS	Y	N

ENMT

HEARING LOSS	Y	N
EAR PAIN	Y	N
PAIN IN NECK	Y	N
STIFF NECK	Y	N
RINGING IN EARS	Y	N
SORE THROAT	Y	N
PAIN IN MOUTH	Y	N

RESPIRATORY

COUGH UP BLOOD	Y	N
ASTHMA	Y	N
SLEEP APNEA	Y	N
FREQUENT BRONCHITIS	Y	N
COUGH UP SPUTUM	Y	N
WHEEZING	Y	N
EMPHYSEMA	Y	N
SHORTNESS OF BREATH	Y	N

GI

NAUSEA	Y	N
ABDOMINAL PAIN	Y	N
DARK OR BLACK STOOL	Y	N
TROUBLE SWALLOWING	Y	N
VOMITING	Y	N
BLOOD IN STOOL	Y	N
HEARTBURN	Y	N

GU

FREQUENT URINE INFECTIONS	Y	N
BLOOD IN URINE	Y	N
KIDNEY STONES	Y	N
FREQUENT URINATION	Y	N
IMPOTENCE	Y	N

MUSCULOSKELETAL

BONE OR JOINT PAINT	Y	N
ARTHRITIS	Y	N
JOINT SWELLING	Y	N
MUSCLE ACHES	Y	N

SKIN

SKIN PROBLEMS	Y	N
CHANGE IN MOLES	Y	N
RASH	Y	N
SKIN CANCER	Y	N
ITCHY SKIN	Y	N

NEUROLOGICAL

STROKE/STROKE LIKE SYMPTOMS	Y	N
LOSS OF MEMORY	Y	N
CONFUSION	Y	N
SEIZURES	Y	N
HEADACHES	Y	N