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**

| | Coronary Or Peripheral | |
|---|---|---|
| Stent Placement: | ☐ Yes | ☐ No |
| 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:

_____

_____

**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:**

_____

_____

_____