



Date _____

3131 BERGER AVENUE
SAN DIEGO, CA 92123

HEALTH AND CLINICAL HISTORY

Please take time to *complete sections 1 and 3 only*. This will enable the doctor to best assess your current medical status and provide the best course of care. If you do not know the answer to a question, or you are unsure, please insert a question mark in the space.

Thank you for your time and cooperation.

SECTION 1

Name: _____ Phone () _____

Address: _____

Referring Physician: _____

Address: _____

Date of Birth: _____ Sex: _____ Marital Status _____ Age: _____

Present reason for seeing doctor: _____

Duration of Symptoms: _____

SECTION 2

For staff use only

SECTION 3

A. CARDIOVASCULAR HISTORY ♥

Please ✓ and date any of the following that apply to you:

	Date(s)	Location (city or town)
<input type="checkbox"/> Myocardial infarction (heart attack)	_____	_____
<input type="checkbox"/> Heart catheterization	_____	_____
<input type="checkbox"/> Coronary artery bypass surgery	_____	_____
<input type="checkbox"/> Coronary angioplasty	_____	_____
<input type="checkbox"/> Treadmill exercise test	_____	_____
<input type="checkbox"/> Ultrasound of heart	_____	_____
<input type="checkbox"/> Holter monitor	_____	_____
<input type="checkbox"/> Other cardiac procedure	_____	_____

Please ✓ and complete the following that pertains to your history:

- Rheumatic fever • At what age? _____
- Rheumatic heart disease • At what age? _____
- Congenital heart disease • What type? _____
- Heart murmur • First noted when? _____
- Chest discomfort • How frequent and when? _____
- Palpitations
- Light-headedness/dizziness/fainting
- Shortness of breath on exertion
- Shortness of breath requiring 2 or more pillows for comfortable sleep
- Waking at night short of breath
- Unusual fatigue
- Previous leg vein stripping operation
- Phlebitis
- Swelling in the ankles
- Leg discomfort with walking • How far can you walk before pain? _____

B. CARDIOVASCULAR RISK FACTORS

Please ✓ and complete the following that pertains to your history/lifestyle:

- Smoking history • Do you smoke now? _____ Quit date _____
How many years did you smoke? _____ How many packs/day? _____
- High blood pressure • How long? _____ Treatment? _____
- High blood cholesterol • What was your last result? _____
Have you ever been treated with medicines for your cholesterol? _____
What _____
- Diabetes mellitus
- Immediate family history of heart disease _____
- Number of alcoholic drinks consumed per week! _____
- Do you regularly exercise 3 times a week or more? _____
If so, what do you do? _____
- What is the most vigorous physical activity you perform? _____
- What was your weight at 21 years of age? _____
- Are you currently on any special diet plan? _____ If so, what type _____

Rate your level of stress over the last 12 months: (circle the appropriate #)

1 2 3 4 5 6 7 8 9 10
Low Moderate High

Rate your level of stress over the last 30 days:

1 2 3 4 5 6 7 8 9 10
Low Moderate High

How do you relieve tension and stress? _____

C. CURRENT MEDICATIONS

Please list the current medications that you are taking:

Medicine	Dose	Frequency/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. ALLERGIES

Please list any drug allergies that you have and the reactions that you have to them:

E. PAST MEDICAL & SURGICAL HISTORY (IN CHRONOLOGICAL ORDER)

Hospitalizations/Surgeries	Reason	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

F. SOCIAL & PERSONAL HISTORY

- 1. Where were you born? _____ Highest level of education: _____
- 2. Children: How many? _____ What ages? _____
- 3. How long have you lived in San Diego or wherever you currently reside? _____
- 4. What is your current occupation? _____

G. FAMILY HISTORY

Please indicate the health status of each of the following family members:
(If deceased, please indicate cause & approximate age)

Father: _____

Mother: _____

Siblings: _____

H. REVIEW OF SYSTEMS

Please answer the following as it applies to your history:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Dysfunction
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones
<input type="checkbox"/>	<input type="checkbox"/>	Teeth/Gum Problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with Urination			

Reviewed with Patient _____

Date _____

SECTION 4

For Staff use only

Height: _____ Weight: _____

VITAL SIGNS:

		Right arm	Left arm
Blood pressure:	Supine	____ / ____	____ / ____
	Sitting	____ / ____	____ / ____

Heart rate: _____ Temp: _____

Respirations: _____

HEENT: _____ Arcus: _____ Xanthelasma: _____

FUNDI: Normal AV Nicking Narrowing Hemorrhages Exudates

NECK: Normal JVD _____ Carotid bruits _____

Thyromegaly _____

LUNGS/CHEST: Clear AP diameter _____ Other _____

HEART: PMI _____ Lift _____ Heart sounds: _____ S3 S4
 Systolic murmur Diastolic murmur Rub Click

ABDOMEN: Hepatomegaly Splenomegaly Bruits Tenderness
 Pulsatile masses Scars

EXTREMITIES: Cyanosis Clubbing Edema Tenderness Bruits
 Varicosities

PULSES: (L) Fem _____ Pop _____ PT _____ DP _____
(R) _____

SKIN:

NEUROLOGIC: Orientation _____ Crainial nerves II-XII _____
 Sensation _____ Motor _____ DTR's _____

RECENT LABORATORY TESTS: _____

ASSESSMENT:

PLAN:

SDCC Physician

Date