Confidential Health History

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NORTH CAROLINA ARRHYTHMIA ASSOCIATES

Name:		DOB:		Age:		SSN:	

Reason you are here:

If you are experiencing chest discomfort, when does it occur?

Describe the sensation:

How long does it last?

When did it start?

Please provide your past medical history (including surgery and hospitalizations):

Family Medical History

Father	Living?	Heart Disease?	Stroke?
Mother	Living?	Heart Disease?	Stroke?
Grandparents	Living?	Heart Disease?	Stroke?
Brother/Sister	Living?	Heart Disease?	Stroke?
Aunt/Uncle	Living?	Heart Disease?	Stroke?
Children	Living?	Heart Disease?	Stroke?

Patient Cardiac Risk Factors

High Blood Pressure	☐ Check if "yes"
Smoking	☐ Check if "yes"
Obesity	☐ Check if "yes"
Cholesterol	☐ Check if "yes"
Diabetes	☐ Check if "yes"
Family History	☐ Check if "yes"

Allergies

Iodine	☐ Check if "yes"
Penicillin	☐ Check if "yes"
Seafood or Shellfish	☐ Check if "yes"

Other Reason(s) For Visit:

Treadmill test	☐ Check if "yes"
Palpitations	☐ Check if "yes"
Rapid heartbeat	☐ Check if "yes"
Poor circulation	☐ Check if "yes"
Shortness of breath	☐ Check if "yes"
Swelling	☐ Check if "yes"
High Blood Pressure	☐ Check if "yes"
Heart murmur	☐ Check if "yes"
Rheumatic Fever	☐ Check if "yes"

Other (please list below):

Other Health History

Abdominal Pain	☐ Check if "yes"	Heat/cold Intolerance	☐ Check if "yes"
Asthma	☐ Check if "yes"	Hepatitis	☐ Check if "yes"
Blackout	☐ Check if "yes"	Indigestion	☐ Check if "yes"
Claudication	☐ Check if "yes"	Liver/Gallbladder	☐ Check if "yes"
Constipation	☐ Check if "yes"	Numbness	☐ Check if "yes"
Cough	☐ Check if "yes"	Painful Urination	☐ Check if "yes"
Dizziness	☐ Check if "yes"	Phlebitis	☐ Check if "yes"
Emphysema	☐ Check if "yes"	Pneumonia	☐ Check if "yes"
Excessive Thirst	☐ Check if "yes"	Seizers	☐ Check if "yes"
Excessive Hunger	☐ Check if "yes"	Sinus Problem	☐ Check if "yes"
Fainting	☐ Check if "yes"	Sore Throat	☐ Check if "yes"
Head Injury	☐ Check if "yes"	Urgency/Hesitancy	☐ Check if "yes"
Headaches	☐ Check if "yes"	Varicose Veins	☐ Check if "yes"
Hearing	☐ Check if "yes"	Vision	☐ Check if "yes"
Heartburn	☐ Check if "yes"	Weight Gain/Loss	☐ Check if "yes"

Current Medications:

Social History

Smoke?	☐ Check if "yes"	# per day:		Quit:	☐ Check if "yes"	Date quit:	
Alcohol?	☐ Check if "yes"	# per day:		Caffeine?	☐ Check if "yes"	# per day:	
Rec. Drugs?	☐ Check if "yes"	# per day:		Diet:			