

**BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
CARDIOLOGY PRACTICE**

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

Name: _____
ID #: _____
Date: _____

Reason for visit: _____

Medications: _____

Allergies: _____

Medical History:

• **Patient medical history:**

Diabetes	Y	N	COPD	Y	N
Hypertension	Y	N	Bleeding tendency	Y	N
Stroke	Y	N	Acute infections	Y	N
Heart trouble	Y	N	Poor circulation	Y	N
Cholesterol	Y	N	Hereditary defects	Y	N
Emphysema	Y	N			

If yes, explain: _____

Previous Hospitalizations/Surgeries/Serious Injuries	When?
_____	_____
_____	_____
_____	_____

• **Patient social history:**

Marital status: Single: ___ Married: ___ Separated: ___ Divorced: ___ Widowed: ___

Use of alcohol: Never: ___ Rarely: ___ Moderate: ___ Daily: ___

Use of tobacco: Never: ___ Quit Smoking: ___ Current packs per day: ___

Use of drugs: Never: ___ Type/Frequency: _____

Excessive exposure at home or work to: Fumes: ___ Dust: ___ Solvents: ___ Air-borne particles: ___ Noise: ___

Occupation/Work: _____

• **Family medical history:**

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Review of Systems: Please circle if you are experiencing any of the following:

• **CONSTITUTIONAL SYMPTOMS**

Good General healthy lately _____ Yes No
 Recent weight change _____ Yes No
 Decreased appetite _____ Yes No
 Fever/night sweats _____ Yes No
 Fever/night sweats _____ Yes No
 Headaches _____ Yes No

• **EYES**

Eye disease or injury _____ Yes No
 Wear glasses/contact lenses _____ Yes No
 Vision problems _____ Yes No
 Glaucoma/cataracts _____ Yes No

• **EARS/NOSE/THROAT**

Chronic sinus problems of rhinitis _____ Yes No
 Nose bleeds/mouth sores _____ Yes No
 Sore throat or voice change/swollen glands _____ Yes No
 Problems with hearing _____ Yes No

• **CARDIOVASCULAR**

Heart trouble _____ Yes No
 Chest pain or angina pectoris _____ Yes No
 Palpitations _____ Yes No
 Shortness of breath with walking or lying flat _____ Yes No
 Swelling of feet, ankles or hands _____ Yes No
 Fast/slow heart beat _____ Yes No
 Peripheral vascular disease _____ Yes No

• **RESPIRATORY**

Chronic or frequent coughs _____ Yes No
 Spitting up blood _____ Yes No
 Shortness of breath _____ Yes No
 Asthma or wheezing _____ Yes No
 Snoring _____ Yes No

• **GASTROINTESTINAL**

Loss of appetite _____ Yes No
 Change in bowel habits _____ Yes No
 Nausea or vomiting _____ Yes No
 Frequent diarrhea/constipation _____ Yes No
 Rectal bleeding or blood in stool _____ Yes No
 Abdominal pain _____ Yes No
 Peptic ulcer (stomach or duodenal) _____ Yes No

• **GENITOURINARY**

Problems with urination _____ Yes No
 Kidney stones _____ Yes No
 Sexual difficulty _____ Yes No
 Male – testicle pain/lumps _____ Yes No
 Prostate problems _____ Yes No
 Female-irregular periods _____ Yes No
 Estrogen replacement _____ Yes No
 Hysterectomy _____ Yes No
 Late menstrual periods _____ Yes No

• **MUSCULOSKELETAL**

Joint pain _____ Yes No
 Joint stiffness or swelling _____ Yes No
 Weakness of muscles or joints _____ Yes No
 Muscle pain or cramps _____ Yes No
 Back pain _____ Yes No
 Difficult/pain in walking _____ Yes No

• **INTEGUMENTARY (skin, breast)**

Rash or itching _____ Yes No
 Change in skin color _____ Yes No
 Change in hair or nails _____ Yes No
 Varicose veins _____ Yes No
 Breast pain _____ Yes No
 Breast lump _____ Yes No
 Breast discharge _____ Yes No

• **NEUROLOGICAL**

Frequent or recurring headaches _____ Yes No
 Light-headed or dizzy _____ Yes No
 Convulsions or seizures _____ Yes No
 Numbness/tingling sensations _____ Yes No
 Tremors _____ Yes No
 Paralysis _____ Yes No
 Stroke _____ Yes No
 Head Injury _____ Yes No

• **PSYCHIATRIC**

Memory loss or confusion _____ Yes No
 Nervousness _____ Yes No
 Depression _____ Yes No
 Insomnia _____ Yes No

• **ENDOCRINE**

Glandular/hormone problem _____ Yes No
 Thyroid disease _____ Yes No
 Heat or cold intolerance _____ Yes No
 Diabetes (insulin or non insulin, circle one)
 _____ Yes No
 Excessive thirst or urination _____ Yes No

• **HEMATOLOGIC/LYMPHATIC**

Bleeding or bruising tendency _____ Yes No
 Slow to heal after cuts _____ Yes No
 Anemia _____ Yes No
 Phlebitis _____ Yes No
 Past transfusion _____ Yes No

• **ALLERGIC/IMMUNOLOGIC**

History of skin or other adverse reaction to:
 Penicillin or other antibiotics _____ Yes No
 Morphine, Demerol, other narcotics _____ Yes No
 Novocaine, other anesthetics _____ Yes No
 Aspirin, other pain remedies _____ Yes No
 Tetanus antitoxin, other serums _____ Yes No
 Iodine, merthiolate, other antiseptic _____ Yes No
 Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

Reviewed by: _____

Date: _____