Cardio Thoracic Surgeons Medical History

Patient Name: _____ Chart: _____
Primary Phone: _____ Date: _____
Pharmacy _____ Phone: _____ Zip _____ Location: _____
Primary Care M.D. _____ Phone: _____ Fax: _____
Cardiologist _____ Phone: _____ Fax: _____

MEDICAL HISTORY *(check all that apply)* ☐ **I HAVE NO KNOWN MEDICAL PROBLEMS**

☐ Heart Disease	☐ Seizures	☐ MRSA	☐ Diabetes; Type ___	☐ Kidney Disease
☐ Atrial Fibrillation	☐ COPD/Emphysema	☐ Cancer	☐ Thyroid Disorder	☐ Liver Disease
☐ High Blood Pressure	☐ Asthma	☐ Ulcer	☐ Rheumatoid Arthritis	☐ Hepatitis;Type___
☐ Prior Blood Clot	☐ Sleep Apnea	☐ Reflux	☐ Fibromyalgia	☐ HIV/AIDS
☐ Stroke/TIA	☐ Tuberculosis	☐ Menopause	☐ Gout/Pseudogout	☐ Depression/Anxiety

☐ Other: _____

CURRENT MEDICATIONS: *(please list **ALL** current medications along with **dose & frequency**. Include aspirin & supplements)*

Select if using: ☐ Pain Medication ☐ Blood thinner ☐ Chemotherapy ☐ Birth Control ☐ Chronic Steroids

Currently under Pain Management? ☐ No ☐ Yes Doctor _____ Condition _____

ALLERGIES: ☐ None ☐ Latex ☐ Eggs/Chicken ☐ Nickel ☐ Penicillin
☐ Medications (describe reaction) _____

PRIOR SURGERY *(include ALL)* ☐ Pacemaker ☐ Defibrillator ☐ Cardiac Stent(s)

Will you accept blood transfusion if necessary? ☐ Yes ☐ No **Any prior complications with anesthesia?** ☐ Yes ☐ No
Do you have a personal or family history of Malignant Hyperthermia? ☐ Yes ☐ No

FAMILY HISTORY:	Parent	Sibling
Arthritis		
Diabetes		
Heart Disease		
Clotting Disorder		
Osteoporosis		
Unknown Family History		

SOCIAL HISTORY *(check appropriate box and fill in blanks)*

Marital Staus	**Alcohol**	**Tobacco**	**Drug Use**
☐ Single	☐ None	☐ Never ☐ Smokeless	☐ Never ☐ Prior
☐ Married	☐ Rarely	☐ Former; Stopped _____	☐ Current IV Use
☐ Divorced	☐ Weekly	☐ Current	☐ Other
☐ Widowed	☐ Daily	# packs per day _____	**Hand Dominance**
☐ Other	# drinks___	# years smoked _____	☐ Right ☐ Left

Occupation/School/Sports/Hobbies: _____

REVIEW OF SYSTEMS *(please circle yes or no)*

HEIGHT: _____ WEIGHT: _____

General		**Cardiovascular**		**Gastrointestinal**		**Skin**	
Weight Gain/Loss	Yes/No	Chest Pain	Yes/No	Nausea/Vomiting	Yes/No	Rash/Itching	Yes/No
Fever/Chills	Yes/No	Palpitations	Yes/No	Diarrhea	Yes/No	**Neurological**	
Night Sweats	Yes/No	Heart Murmur	Yes/No	**Endocrine**		Numbness	Yes/No
Fatigue	Yes/No	**Respiratory**		Increased Thirst	Yes/No	Weakness	Yes/No
Dizziness	Yes/No	Cough/Sputum	Yes/No	Excessive Hunger	Yes/No	Tremor/Shaking	Yes/No
Ear-Eyes-Nose-Throat		Difficulty Breathing	Yes/No	**Genitourinary**		**Psychological**	
Vision Change	Yes/No	**Musculoskeletal**		Urinary Infections	Yes/No	Depression	Yes/No
Ringing in Ears	Yes/No	Joint Pain	Yes/No	Incontinence	Yes/No	Panic attacks	Yes/No
Nose Bleeds	Yes/No	Backache	Yes/No	Dialysis	Yes/No	Mood Swings	Yes/No
Hard to Swallow	Yes/No	Muscle Pain	Yes/No				

Are you currently taking Plavix or Coumadin? Y or N _____ Last Dose _____