CCOM MEDICAL GROUP

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CARDIAC - Comprehensive Assessment (H&P)

Name: _____ Date: _____

Age: _____ Date of Birth: _____/_____/_____ Sex M / F (circle one)

Primary Medical Problem_____
_____

Other Medical Problems_____
_____

PAST HISTORY: Have you had any of the following? Check only if your answer is yes.

___Heart Disease	____Anemia	____Thyroid Problems (Goiter)	___Other
___Heart Murmur	____Bleeding Tendencies	____Eye or Ear Problems	_____
___High Blood Pressure	____Other Blood Diseases	____Stomach Ulcer	_____
___Stroke	____Rheumatic Fever	____Gallbladder Disease	_____
___High cholesterol	____Gout	____Liver Disease (Jaundice)	_____
___Lung Disease	____Hay Fever	____Bowel Problems	
___Tuberculosis	____Cancer	____Arthritis	
___Diabetes	____Migraine Headaches	____Nervous Condition	
___Kidney Disease	____Asthma	____Osteoporosis	

Has anyone in your immediate family had any of the following? Specify relationship.

_____	Heart Disease	_____	Diabetes
_____	Heart Murmur	_____	High Cholesterol
_____	High Blood Pressure	_____	Rheumatic Fever
_____	Tuberculosis	_____	Bleeding Tendencies
		_____	Other Blood Diseases

For the following family members, list any medical problems not covered previously. If deceased, give cause of death.

Father_____
Mother_____
Brother(s)_____
Sister(s)_____

OPERATIONS: _____

HOSPITALIZATIONS: _____

INJURIES: _____

IMMUNIZATIONS: _____

ALLERGIES: (Write NONE if none) _____

LAST PHYSICAL EXAM: Date: _____ Where: _____ By Whom: _____

List ALL medications you are taking.
(Please bring ALL your medications with you when you come in for your appointment.)

List all current Medications & Dosages_____
_____
_____
_____

PERSONAL HABITS

Do you Smoke? _____	How Much? _____	For how long?_____
Drink Alcohol? _____	How Much? _____	For how long?_____
Drink Caffeine Drinks? _____	How Much? _____	For how long?_____
Exercise Routinely? _____	How Much? _____	For how long?_____

OCCUPATIONAL

Are you presently employed? YES / NO If YES what kind of work do you do? _____

Are you dissatisfied with your present type of work? YES / NO Are you under a lot of stress in your work? YES / NO

Do you work more than 60 hours a week? YES / NO

SOCIAL HISTORY

Are you married? YES / NO Are there any problems with your married life? _____

Is your present home life causing your unhappiness? _____

_____

REVIEW OF CARDIOVASCULAR SYSTEM (Check only if YES)
Do you have any of the following?

_____ Chest discomfort, pain, pressure or tightness.

How long? _____ How often? _____
Is it aggravated by:

_____ Working? _____ Climbing stairs? _____ Walking?

_____ Running? _____ Excitement? _____ Cold Weather?

_____ Trouble breathing?

How long? _____ How often? _____
Is it aggravated by:

_____ Working? _____ Climbing stairs? _____ Walking?

_____ Running? _____ Excitement? _____ Cold Weather?

_____ Wake up at night with shortness of breath?

_____ Use 2 or more pillows to help you breathe at night?

_____ Unusual heart beats?

_____ Fast heart beat? _____ Skip heart beets?

How long? _____

How often? _____
Is it aggravated by?

_____ Working? _____ Climbing stairs? _____ Walking?

_____ Running? _____ Excitement? _____ Cold Weather?

Do you have swelling of the feet or ankles? YES / NO _____

Do you have leg pain or cramps? YES / NO _____

Do you have cold, numb, very white or blush fingers and or toes? YES / NO _____

Have you ever been told that your EKG was abnormal? YES / NO _____

Have you ever had any other abnormal tests? YES / NO _____

REVIEW OF OTHER SYSTEMS (Check only if YES)
Do you have any of the following?

GENERAL
__Recent weight loss
__Recent weight gain
__Fever / Chills
__Fatigue / Weakness
__Drinking a lot of fluid

SKIN
__Itching
__Rash
__Change in color
__Abnormal growth
__Sores

EYES
__Blurring
__Pain
__Failing vision
__Double vision
__See “floating lights” / colors

EARS, NOSE, THROAT
__Trouble hearing
__Ringing of the ear
__Nose bleeds
__Hoarseness
__Bleeding gums
__Runny nose
__Nasal Congestion
__Ears hurting
__Sore throat
__Sinus pain

NECK
__Swelling in neck
__Stiffness / pain

RESPIRATORY
__Chest congestion
__Cough
__Sputum production
__Coughing of blood
__Shortness of breath
__Wheezing
__Pain on deep breathing
__Frequent Colds
__Difficulty of breathing

CARDIOVASCULAR
__Use 2 or more pillows at night
__Swelling in feet/ankles
__Shortness of breath
__Shortness of breath at night
__Ever had an abnormal EKG
__Unusual / skipped heartbeats
__Fast heart beat
__Chest pain

GASTROINTESTINAL
__Change in eating habits
__Stomach pain or upset
__Burping a lot
__Trouble swallowing
__Heartburn
__Nausea or vomiting
__Vomiting of blood
__Black stools
__Constipation
__Change in bowel movements
__Diarrhea
__Blood from rectum

GENITOURINARY
__Pain on urination
__Hard to start urinary flow
__Scanty urination
__Blood in urine
__Frequent night urination
__Any leakage of urine
__Kidney stones
__Any retention of urine
__Problem passing urine
__Pass water frequently
__Problem with prostate (men)

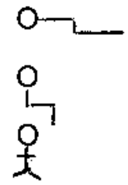
GYN/WOMEN
__Breast lumps
__Premenstrual symptoms
__Vaginal itching/ discharge
__Menopause
__Problem with menstrual period
__Pass clots with your period
__Discharge from nipples
__Lumps in breast
__Heavy flow (6 pads or more per day)
__Use birth control measure
__Vaginal bleeding

MUSCULOSKELETAL
__Joint or muscle problems
__Shoulder pain
__Back pain
__Pain in legs or feet
__Pain in walking
__Swelling of joints
__Unsteady walking
__Any muscle jerking
__Any strokes

CENTRAL NERVOUS SYSTEM
__Headaches
__Dizziness
__Convulsions
__Passing out
__Memory loss / Trouble remembering
__Seizures
__Numbness / Tingling
__Tremors
__Paralysis
__Difficulty swallowing
__Difficulty speaking

NEUROPSYCHOLOGICAL
__Depression
__Nervous breakdown
__Mental Problems
__Psychotherapy / counseling
__Alcohol problem
__Drug problem
__Serious marital problems

____________ R ____________________ Weight ____________________ Height ____________________

Blood Pressure	Right	/	Left	/		PR
		/		/		Reg Irreg
		/		/		

Appearance: ____

HEENT: ____

FUNDI: ____

Neck: ____

Chest: ____

CARDIOVASCULAR:

NECK VESSELS:

Jugular veins ____________________ Hepatojugular reflux ____________________

Carotid pulses ____

Carotid Bruit ____

HEART:

PMI ____

Heave ____

S1 ____________ S2 ____________ S3 ____________ S4 ____________

Click ____________________ Rub ____________________

Murmurs: Systolic ______________________________

Diastolic ______________________________

PULSES:

Brachial ____________________ Radial ____________________

Femoral ____________________ Popliteal ____________________

Post tibial ____________________ Dorsalis pedis ____________________

VEINS:

____________________ Varicose veins ____________________

Leg edema ____________________ Sacral Edema ____________________

LUNGS: ____

____

ABDOMEN:

Hepat ____________________ Abd Aorta ____________________

Spleen ____________________ Mass ____________________

LOWER EXTREMETIES: ____

RECTAL: ____

GU: ____

NEUROLOGICAL: ____

____