Medical Director: Mahfouz El Shahawy, MD, MS, FACP, FESC, FASH, FSCCT, FAHA, FACC
Clinical Professor of Medicine, Universities of Florida and South Florida

PATIENT HEALTH HISTORY

Please complete this form and bring it with you to your appointment. We will review this information with you during your visit and can add information if needed.

1. Demographics

Name________________________________ Date of birth: month____ day____ year___

Address: ____

Primary Phone (___)_______-_________ Alternate Phone (___)_________-_____________

Email address (kept confidential) ____

Race (predominant): ☐ Asian ☐ Black ☐ Hispanic ☐ White/Caucasian
Other/list____

Occupation: _____________________jobtitle/description______________________________

Occupation (type): ☐ sedentary ☐ semi active ☐ active: notes_______________________________

Perception of work stress: ☐ high ☐ moderate ☐ low

Highest level of Education: ☐ elementary/jr. high ☐ high school ☐ college ☐ graduate school/PhD

Living arrangement: ☐ alone ☐ with spouse/partner ☐ with relative_____________________

Do you have children: ☐ no ☐ yes (if yes specify below)
age:____ M/F age: ____ M/F age: ____M/F age: ____ M/F

additional__________________

Would you like us to send your results to another health care provider ? Yes _____ No _____

- **If so, we will need his or her <u>first</u> and <u>last</u> names and <u>complete address</u>.**

Provider's name: ____
Clinic name: ____
Street address: ____

City: ____ State: ______ Zip: ______________
Phone (_______) _________ - _________ Fax: (________) _________ - __________

2. Please complete family history to the best of your knowledge. After each condition fill in the age (or approximate age if known) when it was first identified.

Patient Name:______________________
DOB:_____________________________

Medical Director: Mahfouz El Shahawy, MD, MS, FACP, FESC, FASH, FSCCT, FAHA, FACC

Clinical Professor of Medicine, Universities of Florida and South Florida

Mother: Living: ☐ yes ☐ no age or age at death_____

Condition	Yes/ Age	Condition	Yes/ Age
High blood pressure		Failing kidneys age	
Heart attack		Diabetes	
Heart failure		Stroke	
Heart Surgery/stent/balloon		High lipid/cholesterol	
Angina (heart pain)		Smoking	
Leg circulation problem		Dementia/Alzheimer's	

Father: Living: ☐ yes ☐ no age or age at death_____

Condition	Yes/ Age	Condition	Yes/ Age
High blood pressure		Failing kidneys age	
Heart attack		Diabetes	
Heart failure		Stroke	
Heart Surgery/stent/balloon		High lipid/cholesterol	
Angina (heart pain)		Smoking	
Leg circulation problem		Dementia/Alzheimer's	

Siblings: Number of sisters: ______ list ages of living___________________ or at death_________
Number of brothers: _____ list ages of living___________________ or at death________________
Check any conditions listed in any of your siblings and age (or approximate age) condition was identified.

Condition	Yes/ Age	Condition	Yes/ Age
High blood pressure		Failing kidneys age	
Heart attack		Diabetes	
Heart failure		Stroke	
Heart Surgery/stent/balloon		High lipid/cholesterol	
Angina (heart pain)		Smoking	
Leg circulation problem		Dementia/Alzheimer's	

Grandparents	**√ if living**	**Age now or at death**	**Cardiovascular Conditions, age identified, if known cause of death**
Mothers mother			
Mothers father			
Fathers mother			
Fathers father			

Family History Comments: ____
____
____

Patient Name:_____________________
DOB:_____________________________

Medical Director: Mahfouz El Shahawy, MD, MS, FACP, FESC, FASH, FSCCT, FAHA, FACC

Clinical Professor of Medicine, Universities of Florida and South Florida

3. Personal History

Check the box below for any conditions that you currently have or have had in the past. Include the age you were when the condition was identified.

Condition	Yes/ Age	No		Condition	Yes/ Age	No
High blood pressure				Poor leg circulation		
Heart attack				Diabetes		
Heart failure				Stomach ulcer		
Heart murmur				Stroke		
Angina (heart pain)				High lipid/cholesterol		
Asthma				Emphysema		
Cancer				Chemotherapy/radiation		
Blood clots in leg or lung				Depression		
Liver Problem						

Comments/Notes: ______________________________

4. Past Medical History

List medical problems for which you have been treated. Include hospital visits, surgeries etc.

Condition	Year		Condition	Year

5. Past Cardiovascular Testing

List past testing and the date or year of the test (example: exercise tests, ECHO, cholesterol, heart scan, etc.)

Test	Mo/day/yr		Test	Mo/day/yr

Comments/Notes: ______________________________

6. Allergies

List any allergy and type of reaction (include medications, food, seasonal, environmental [for example, cats, dogs, latex, smoke, etc.]).

☐ No known drug allergies			
Allergy to	**Description of Reaction**	**Allergy to**	**Description of Reaction**
1.		**3.**	
2.		**4.**	

Patient Name:______________________

DOB:____________________________

7. Medications

List type and amount of medication you use on a regular basis. Include prescription, over-the- counter, birth control, hormones, vitamins, herbs, nutritional supplements, and recreational drugs (examples: marijuana, cocaine, IV drugs).

Medication	Dosage/frequency	Reason for taking	Started: mo/yr
Example: Aspirin	81mg once per day	prevention	3/2001

8. Exercise

Do you get 30 minutes of steady physical exertion/exercise 3-4 times per week? ☐ Yes ☐ No

Type of activity ☐ walking, ☐ biking, ☐ yard work/mowing lawn, ☐ swimming
☐ running ☐ jogging ☐ house hold chores ☐ Other ____________________

9. Nutrition

Fill in the box of the number closest to your best estimate of servings per day.

Number of servings per day (**examples are in parentheses**)						
Foods with fat/cholesterol (fried foods, fatty meats, junk food)	**0 ☐**	**1 ☐**	**2 ☐**	**3 ☐**	**4 or more ☐**	
Fruits and vegetables (½ cup cooked, 1 cup raw)	**0 ☐**	**1 ☐**	**2 ☐**	**3 ☐**	**4 or more ☐**	
Caffeine (1 cup coffee, soda etc.)	**0 ☐**	**1 ☐**	**2 ☐**	**3 ☐**	**4 or more ☐**	
Alcohol servings (12 oz. beer, 4 oz. wine, 1½ oz. in mixed drink) . If not daily number of servings per month________	**0 ☐**	**1 ☐**	**2 ☐**	**3 ☐**	**4 or more ☐**	
Calcium servings (dairy foods, 8 oz. milk, yogurt, cheese, ice cream)	**0 ☐**	**1 ☐**	**2 ☐**	**3 ☐**	**4 or more ☐**	
I add salt to my food and or eat salty prepared foods	**Never ☐**	**Seldom ☐**	**Sometimes ☐**	**Usually ☐**	**Always ☐**	
Check if you currently use a special diet?	**Vegetarian ☐**	**Weight Watchers ☐**	**High Protein/ Low Carb ☐**	**Slim Fast ☐**	**Diabetic ☐**	**________ Other ☐**

Patient Name:______________________
DOB:_____________________________

CARDIOVASCULAR HEALTH ASSESSMENT CENTER

AT THE CARDIOVASCULAR CENTER OF SARASOTA

Medical Director: Mahfouz El Shahawy, MD, MS, FACP, FESC, FASH, FSCCT, FAHA, FACC

Clinical Professor of Medicine, Universities of Florida and South Florida

10. Tobacco use

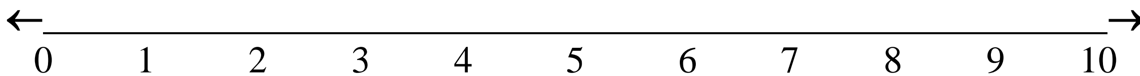
1. Never used tobacco : ☐	2. Ex-tobacco user: Quit date__________	3. Currently use: ☐

Type and amount of tobacco use	Average number per day	Number of years
Cigarettes: ☐		
Cigars: ☐		
Pipe: ☐		
Other: ☐_________________		

11. Enjoyment of Life Scale

Enjoyment of life perception scale: place an X on the line where you think you fit best.

I do not enjoy life not at all I enjoy life fully



0 1 2 3 4 5 6 7 8 9 10

12. Cardiovascular System Review

Check if you have experienced any of these symptoms in the last 6 months.

	Yes	No		Yes	No
Chest discomfort with exercise			Swelling of legs		
Chest discomfort at rest			Calf pain with walking		
Irregular or fast heart beat			Unexplained dizziness		
Shortness of breath			Unexplained weight loss		
Chronic cough			Unexplained thirst		
Wheezing			Indigestion/heartburn		
Up to urinate at night			Headache		
Erection problems			Memory problems		
Weakness (arms/legs)			Paralysis		

Comments:____

13. Phase of Life

Women only: check box that applies best to you.

☐ I am before menopausal ☐ experiencing menopause ☐ after menopause (age at last period______)☐ other/NA________________________

14. Heard of center from: Please circle

Mailing Word of mouth print add TV Radio Provider Internet

Other______________________________________

Official use: History reviewed by: ______________________ NP ____________________ MD

Date: __________________ Date: ________

Patient Name:______________________

DOB:________________________________