PALOUSE HEART CENTER
PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

PATIENT HISTORY

Patient Name:	**Date of Birth:**	**Age**
With whom do you live:	**Transportation concerns:**	

Medical History (Please indicate the date symptoms started)
Cardiac Problems:
Cancer:
Thyroid:
Lipids:
Respiratory Problems:
Hypertension:
Rapid Heart Rate:
Shortness of Breath:
Diabetes:

Surgical History	
Type:	**Date (month/year):**
1.	
2.	
3.	
4.	
5.	

Current Medication List		
Name:	**Dosage:**	**Frequency:**
1.		
2.		
3.		
4.		
5.		

Allergies

☐ No Know Drug Allergies
☐ Medication Name: _____ Reaction: _____
☐ Food Name:_____ Reaction:_____
☐ Environmental Name:_____ Reaction:_____

Family History				
	Father	Mother	Brother	Sister
Cardiac History				
Other				

Social History			
Tobacco use	☐ Never ☐ Current ☐ Ex-smoker ☐ Exposure to Second-Hand Smoke Type: ☐ Cigarettes ☐ E-Cigarettes ☐ Cigar ☐ Pipe ☐ Chew Years:_____ Packs per day:_____ Year started:_____ Year Quit:_____		
Alcohol use	☐ No ☐ Yes	Type:	Drinks per day:
Drug Use	☐ No ☐ Yes	Type:	Years:
Caffeine Use	☐ No ☐ Yes	Type:	Drinks per day:
Exercise	☐ No ☐ Yes	Type:	Times per week:

Review of Systems

(Put an X in the box if you have RECENTLY experienced these symptoms)

General			
☐ Fever ☐ Chills	☐ Sweats ☐ Anorexia	☐ Fatigue ☐ Weakness	☐ Malaise ☐ Weight loss ☐ Sleep Disorder
Heart/Vessels			
☐ chest pain at rest ☐ Chest Pain with Exercise	☐ Palpitations ☐ Peripheral edema (Swelling in Legs/Feet) ☐ PND (shortness of breath/coughing at night)	☐ Orthopnea (shortness of breath laying down) ☐ Shortness of Breath ☐ Dyspnea on Exertion (Shortness of breath w/exercise)	☐ Syncope (fainting) ☐ Claudication (leg cramps with exercise) ☐ Orthostatic Symptoms (dizzy standing up)
Respiratory			
☐ Cough ☐ Dyspnea (Shortness of breath) at Rest ☐Excessive Sputum	☐ Hemoptysis (Coughing up Blood) ☐ Wheezing ☐ Pleurisy	☐ Shortness of Breath ☐ History of TB ☐ TB Exposure	☐ Excessive Snoring ☐History of Sleep Apnea ☐Daytime Somnolence (sleeping)
Neurological			
☐ Paralysis ☐ Paresthesias (numbness) ☐ Seizures ☐ Tremors	☐Vertigo ☐ Dizziness ☐ Transient Blindness	☐ Frequent Falls ☐ Frequent Headaches ☐ Difficulty Walking ☐ History of TIA's (mini stroke)	☐ Prior CVA (stroke)
Endocrine			
☐ Cold Intolerance ☐ Heat Intolerance	☐ Polydipsia (excessive thirst) ☐ Polyphagia (excessive hunger)	☐ Polyuria (excessive urination) ☐ Unusual Weight Change	☐ Excessive Sweating ☐ Hair Loss
Digestive			
☐ Nausea ☐ Vomiting ☐ Diarrhea	☐ Constipation ☐ Change in Bowel Habits ☐ Abdominal Pain	☐ Melena (blood in stools) ☐ Hematochezia (rectal bleeding) ☐ Jaundice ☐ Gas Bloating	☐ Indigestions/heartburn ☐ Dysphagia (Difficulty swallowing) ☐ Odynophagia (Painful swallowing)
Urinary/Reproductive			
☐ Dysuria (painful urination) ☐ Hematuria (blood in urine) ☐ discharge	☐ Urinary frequency ☐ Urinary hesitancy	☐ nocturia (frequent urination at night) ☐ Incontinence	☐ genital sores ☐ decreased libido ☐ erectile dysfunction

Musculoskeletal

☐ Back Pain	☐Muscle Cramps	☐ Arthritis	☐ Leg Pain at Night
☐ Joint Pain	☐Muscle Weakness	☐ Sciatica	☐ Leg Pain with Exertion
☐ Joint Swelling	☐ Stiffness	☐ Restless Legs	

Eyes

☐Blurring	☐ Discharge	☐Photophobia (extreme sensitivity to light)
☐Diplopia (double vision)	☐Vision Loss	
☐Irritation	☐Eye Pain	

Skin

☐Rash	☐Dryness
☐Itching	☐Suspicious lesions

Psychiatric

☐Depression	☐Hallucinations
☐Anxiety	☐Paranoia
☐Memory Loss	☐Phobia
☐Suicidal Ideation	☐Confusion

Blood

☐Abnormal Bruising
☐Bleeding
☐Enlarged Lymph Nodes

Allergy

☐Urticaria (Hives)
☐Allergic Rash
☐Hay Fever
☐Recurrent Infections

Ears Nose and Throat

☐Earache	☐Nasal Congestion
☐Ear Discharge	☐Nosebleeds
☐Tinnitus or Ringing in Ears	☐Sore Throat
☐Decreased Hearing	☐Hoarseness

If you have anything else you would like the doctor to know please add this information below

Patient Signature_____ Date_____