

24 hour notice required for reschedule or cancellation of appointments



Cypress Heart
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Dr Mo's Patient History Questionnaire

Appointment Date: _____ Appointment Time: _____
 Patient's Name: _____ Referring Physician: _____
 Patient's Date of Birth: _____ Soc. Security Number: _____
 Street Address _____ City/State/Zip _____
 Telephone Number(s) Home _____ (Cell) _____ (Work) _____

PRESENTING CIRCUMSTANCE

DESCRIBE THE PATIENT'S PRESENT MEDICAL SYMPTOMS (CHIEF COMPLAINT)

Why is the patient here today?

HISTORY OF CHIEF COMPLAINT

Problem	
Onset/When was it first noted?	
Explain any details related to the chief complaint	

ALLERGIES

Does the patient have any allergies to medications, immunizations, or food: YES NO

Item patient is allergic to:	Reaction:

MEDICATIONS

List all medications the patient is currently taking – Please include all over the counter meds and vitamins:

Medication Name	Dosage	How often taken?	Who Prescribed?

♥ **Remember to bring all medications or a current list of medications with you at time of the appointment, including dosage and frequency☺**

REVIEW OF SYSTEMS

Check yes or no for any health problems related these systems. If you answer yes, please explain.

General:	YES	NO	If yes, please explain:
Decreased exercise tolerance?			
Fatigue?			
Weight change? How much?			
Change in appetite?			
Integumentary(Skin):			
Eyes:			
Ears, Nose, & Throat:			
Respiratory:			
Cardiovascular:			
Do you experience chest pain, tightness or pressure? <input type="checkbox"/> At rest <input type="checkbox"/> With activity			
Heart palpitations (racing)?			
Irregular heart beats?			
Have you passed out?			
Gastrointestinal System:			
Genitourinary System:			
Musculoskeletal:			
Neurological:			
Psychiatric:			
Endocrine:			
Hematological/Immunologic:			

ONGOING AND PAST MEDICAL/SURGICAL HISTORY

Does the patient have any ongoing health problems? YES NO

If so, please list: _____

Is the patient currently up to date on required immunizations? YES NO If no, please explain: _____

ILLNESSES	Problem	Date of occurrence
Medical		
Cardiac		
Infectious		
Trauma/Accidents		
PROCEDURES	Procedure	Date of surgery/procedure
Surgeries		
Cardiology		

Please list all doctors the patient sees and why:

Doctor's Name	Type of Doctor	Reason for Seeing

PATIENT'S BIRTH HISTORY

Patient was born term (38 weeks or greater)? Yes No
 Patient was born preterm? Yes No How many weeks' gestation? _____
 Any problems during mother's pregnancy? Yes No If yes, please explain: _____

 Any problems during labor or delivery? Yes No If yes, please explain: _____

 Any problems during the first few weeks of life? Yes No If yes, please explain: _____

SOCIAL HISTORY AND LIFESTYLE (answer if applicable to patient's age):

Are you on a special diet? Yes No What type of diet? _____
 How many cups of caffeinated beverages do you drink on an average day? _____
 Do you drink alcoholic beverages? Yes No If so, how many in an average week? _____
 Do you have a drug dependency? Yes No If yes, please specify _____
 Do you currently smoke? Yes No
 Are you exposed to second hand smoke? Yes No
 Do you exercise on a regular basis? Yes No
 If yes, what do you like to do? _____
 Do you ride in or use your seat belt, car seat, booster seat? Yes No
 What grade are you in school? _____ What school do you attend? _____
 OR
 What is your occupation _____ How many hours per week does it involve? _____

FAMILY MEDICAL HISTORY

Family member	Age	Health	Age at death	Cause of death, if deceased
Father				
Mother				
Brother(s)				
Sister(s)				

Please tell us if there is any history of the following on either side of the patients family.

Questions	Who	Please describe (type, medications, other helpful info)
Family History of heart disease		
Family history of high lipids or cholesterol		
Family history of high blood pressure		
Family history of diabetes mellitus		
Family history of obesity		
Family history of congenital heart disease (born with heart defect)		
Family history of a congenital arrhythmia (electrical heart problem)		
Family history of sudden death		

I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

Signature of Patient if >18 years of age

Date

Signature of Parent or Guardian
if patient is <18 years of age

Date

RELEASE OF INFORMATION

May we give out any medical/financial information to anyone other than the patient, parent or guardian if patient is a minor, treating physician(s) or insurance company? Yes _____ No _____

If yes, please list:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Note: This authorization is not valid unless signed and dated, and will remain in effect until you notify us otherwise.