



**Cypress Heart**  
 9300 East 29th Steet North, Suite 310  
 Wichita, KS 67226  
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Please bring completed history form to your scheduled appointment, if not completed this could delay your office visit.

Thank you

**PATIENT HISTORY FORM**

Appointment Date \_\_\_\_\_ Appointment Time \_\_\_\_\_  
 Name \_\_\_\_\_ Referring Physician \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Soc. Security Number \_\_\_\_\_  
 Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Telephone Number(s) h \_\_\_\_\_ (w) \_\_\_\_\_

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing

**PRESENTING CIRCUMSTANCE**

**DESCRIBE YOUR PRESENT MEDICAL SYMPTOMS (CHIEF COMPLAINT)**

Why are you here? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HISTORY OF CHIEF COMPLAINT**

Problem	
Onset	___ hours ___ days ___ weeks ___ months ___ years
Location	
Radiation	
Quality	
Duration	
Timing	
Severity	
Aggravating Factors	
Relieving Factors	
Associated S/S	

**PAST MEDICAL/SURGICAL HISTORY:**

**DO YOU HAVE ANY ONGOING ILLNESSES OR PAST MEDICAL CONDITIONS SUCH AS:**

	YES	NO		YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Under active (Hypo)	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Where?)	<input type="checkbox"/>	<input type="checkbox"/>	Overactive (Hyper)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (MI)	<input type="checkbox"/>	<input type="checkbox"/>
_____			Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pain in legs with activity	<input type="checkbox"/>	<input type="checkbox"/>
_____			Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
COPD/ Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>			
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____					



<b>Eyes:</b>	<b>YES</b>	<b>NO</b>	
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you experience double vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a history of cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you experienced visual field loss?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Ears, Nose, and Throat:</b>			
Do you have a hearing deficit?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness with changing position?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hoarseness/Change in voice?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Respiratory:</b>			
Do you have a chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Productive?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you coughed up blood?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you experience shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> At rest? <input type="checkbox"/> With Activity?			
Do you wheeze?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Cardiovascular:</b>			
Chest pain, pressure or tightness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> at rest? <input type="checkbox"/> with activity?			
Heart palpitations (racing)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular heart beats?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short of breath lying flat?	<input type="checkbox"/>	<input type="checkbox"/>	<u>How many pillows do you sleep on at night?</u> _____
Waking up panicky short of breath?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you passed out?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling of feet or ankles?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in legs with walking?	<input type="checkbox"/>	<input type="checkbox"/>	<u>Describe distance before pain develops</u> _____
Varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nonhealing sores on legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of blood clots or phlebitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Gastrointestinal System:</b>			
Frequent nausea?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems with constipation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in Stool?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Genitourinary:</b>			
Do you have pain with urination?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sense of urgency to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Awaken frequently to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of bladder, kidney infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of kidney stones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Males: Prostate problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Females: Post menopausal?	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Musculoskeletal:</b>	<b>YES</b>	<b>NO</b>	
Chronic back pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of Gout?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of blood clots in legs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of vein ligation or stripping?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Neurological:</b>			
Temporary blurred vision/loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Temporary weakness and/or tingling involving an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions/Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Psychiatric:</b>			
Do you have a history of depression?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have chronic anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Endocrine:</b>			
High Cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Hematological/Immunologic</b>			
Chronic low blood count/anemia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Latex Allergy?	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>ILLNESSES</b>	Problem / Date of onset	Problem / Date of onset
<b>Medical</b>		
<b>Cardiac</b>		
<b>Infectious</b>		
<b>Trauma</b>		
<b>PROCEDURES</b>	Procedure / Date	Procedure / Date
<b>Surgeries</b>		
<b>Cardiology Invasive</b>		
<b>Peripheral Vascular</b>		

**SOCIAL HISTORY AND LIFESTYLE:**

How many alcoholic beverages (beer, wine, or liquor) do you drink on an average day? \_\_\_\_\_  
 Do you currently smoke  Yes  No What do you smoke? \_\_\_\_\_ How much do you smoke? \_\_\_\_\_  
 How long have you been smoking? \_\_\_\_\_ If you quit smoking, when did you quit? \_\_\_\_\_  
 How many packs per day did you smoke? \_\_\_\_\_ How many years did you smoke before quitting? \_\_\_\_\_  
 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 exercise on a regular basis? \_\_\_\_\_  
 Do you have a history of drug dependency?  Yes  No If yes, specify \_\_\_\_\_  
 Are you:  Single  Married  Divorced  Widowed

How many children do you have? \_\_\_\_\_

What was the highest grade of formal education that you finished? \_\_\_\_\_

Your occupation \_\_\_\_\_ How many hours per week does it involve? \_\_\_\_\_

Any heavy physical exertion while working?  Yes  No If yes, what types of things? \_\_\_\_\_

### FAMILY MEDICAL HISTORY

IF LIVING		Age at death	IF DECEASED Cause
Age	Health		
Father			
Mother			
Brothers			
Sisters			
Any family history of cardiovascular disease, strokes, diabetes or cancer? Please explain: _____			
_____			
_____			
_____			

If you have a **Durable Power of Attorney for Healthcare Needs**, please provide us a copy. This will be included in your electronic medical record for Cypress Heart and allow us to comply with your healthcare directives.

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

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date