



Cypress Heart
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 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"/>			

Eyes:	YES	NO	
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"/>	_____
Ears, Nose, and Throat:			
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"/>	_____
Respiratory:			
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"/>	_____
Cardiovascular:			
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"/>	_____
Gastrointestinal System:			
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"/>	_____
Genitourinary:			
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"/>	_____

Musculoskeletal:	YES	NO	
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"/>	_____
Neurological:			
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"/>	_____
Psychiatric:			
Do you have a history of depression?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have chronic anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine:			
High Cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematological/Immunologic			
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"/>	_____

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

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

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

RELEASE OF INFORMATION

May we give out any medical/financial information to anyone other than yourself, your treating physician(s) or your 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.