HEART of DIXIE, P.C.

1380 E. Medical Center Drive #4100
St. George, UT 84790
(435) 251.2900

PATIENT'S NAME: _____ **Email Address_____**
TODAY'S DATE: _____
DOB: _____

YOUR INABILITY TO FILL OUT THIS FORM COMPLETELY AND ACCURATELY MAY SIGNIFICANTLY AFFECT HOW WE CARE FOR YOU.

OMITTING ANY INFORMATION OR PROVIDING INACCURATE INFORMATION MAY CREATE ADVERSE MEDICAL RESULTS.

IF YOU NEED ASSISTANCE, PLEASE REQUEST HELP FROM THE FRONT DESK. **PLEASE INITIAL: _____**

WHY ARE YOU BEING SEEN IN OUR OFFICE?

_____

_____

PLEASE NAME THE DOCTOR THAT SENT YOU TO OUR OFFICE: DR. _____

ALLERGIES: PLEASE LIST ALL DRUG ALLERGIES AND REACTIONS.

DRUGS	REACTIONS

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.
INCLUDE OVER-THE-COUNTER MEDICATIONS AND VITAMINS.

Medication Name	Medication Strength	How often do you take the medication?

Cardiac Risk Factors

History of tobacco use? **Yes** **No**
Family history of heart disease? **Yes** **No**
History high cholesterol? **Yes** **No**
Do you have high blood pressure? **Yes** **No**
History of diabetes mellitus? **Yes** **No** / If yes, are you on Insulin? **Yes** **No**
Have you been diagnosed with heart disease? **Yes** **No**
History of obesity? **Yes** **No**
Do you live a sedentary (non-active) lifestyle? **Yes** **No**
How old are you?_____
If female, are you menopausal? **Yes** **No** / If yes, are you on any hormone supplements? **Yes** **No**

Past Medical History

Do you, or **have** you had any of the following? (Please circle all that apply)

General Health Profile

Abdominal aortic aneurysm
Anxiety
Anemia
Arthritis (generalized)
Arthritis (osteoarthritis)
Arthritis (rheumatoid)
BPH-prostate enlargement
Cancer: Yes No Type:_____
Carotid artery blockage
-Right
-Bilaterally
Colitis
COPD
Crohn's Disease
Depression
Diabetes
-Insulin dependent
-Non-insulin dependent
Emphysema
Erectile Dysfunction
Gastric Ulcer
GERD/Reflux
Fibromyalgia
Hiatal hernia
Hypothyroidism
Hyperthyroidism
Hypercholesterolemia (high cholesterol)
Hypertension
Hemorrhoids
Kidney stones
Kidney insufficiency
Lyme Disease
Lupus
Macular degeneration
Peripheral Vascular Disease
Panic Attacks
Parkinson's Disease
Polymyalgia
Pulmonary Hypertension
Pulmonary Embolism
Renal Failure
Sleep Apnea
Syncope

Cardiac Health Profile

Angina
Aortic stenosis
Aortic insufficiency
Aortic regurgitation
Atrial flutter
Atrial fibrillation
Bradycardia (slow heart rate)
Cardiomyopathy
Chest pain
Congestive heart failure
Coronary heart disease
Heart attack/MI
Irregular heart beat
Mitral valve: Prolapse, Regurgitation, Stenosis
Palpitations
Pericarditis
Pulmonary valve stenosis
Tachycardia (fast heart rate)
Tricuspid valve: Regurgitation, Stenosis
Wolf Parkinson's White

Please list any other illnesses you have or have had, as well as any broken bones or major burns?

_____

Past Medical History cont.

Do you, or **have** you had any of the following? (Please circle all that apply)

Infectious Disease History

Chicken Pox Measles/Mumps Polio Malaria Tuberculosis HIV/AIDS

Rheumatic/Scarlet Fever Meningitis: Viral/Bacterial Hepatitis: A, B, C

Surgery/Procedure History

Aneurysm repair of the abdomen
Appendectomy
Breast Biopsy
Breast Lumpectomy
Breast removal for cancer (mastectomy)
Breast enlargement
Heart Valve Surgery
    Aortic valve replaced
    Mitral valve replaced
Heart Bypass Surgery
    How Many: _____
    When: _____
    Where: _____
Cataract Removal
    Right eye Left eye Both eyes
    (Did you have lens implants? Yes / No)
Gallbladder Removed
PTCA (balloon angioplasty)
    How Many: _____
    When: _____
    Where: _____

Stent (wire coil) placed in heart artery
    How Many: _____
    When: _____
    Where:_____

Carotid artery surgery (neck)
    Right Left Both
Hemorrhoid surgery
Hip replacement
    Right Left Both
Knee Replacement
    Right Left Both
Lung surgery
Thyroid gland removed
Prostate removed
Prostate "reamed out"
Varicose veins stripped
    Right leg Left leg Both legs
Heart Catheterizations
How Many: _____
    When: _____
    Where: _____
    Who: _____
Hysterectomy:
    Total Partial (Still Have Ovaries)
Shoulder Surgery
    Right Left Both
Tonsillectomy Adenoidectomy
Carpal tunnel surgery
    Right Left Both

Any other surgical procedures, please list:
_____

Trauma History

Have you had any history of trauma? Yes / No
If so, please explain:_____
_____

Cardiac Procedures (Invasive)

Angiogram/Heart Cath Cardioversion Stents Ablation Heart Transplant

Myocardial Biopsy Pacemaker Implant Bypass Surgery Other:_____

Past Medical History cont.

Cardiac Procedures (Non-Invasive)

Echocardiogram Stress Echocardiogram Treadmill Carotid Ultrasound

Nuclear Stress Test Event Monitor Holter Monitor EKG/ECG

Social History

(Please circle all that apply)

1. Do you use alcohol? A)No B)Occasionally C)Regularly D)Excessively E)Alcoholism
2. Do you smoke? A)No B)Yes, How long_____ / How much_____ C)Used to smoke but quit
3. Are you on a special diet? A)No B)Low-fat C)Low-chol D)Diabetic E)Low-sodium F)Other_____
4. Do you Exercise? A)No B)Some C)Regularly D)Daily How long?_____
5. Do you have any history of substance abuse (prescription or non-prescription)? A)Yes B)No
6. What is your marital status? A)Married B)Single C)Divorced D) Widowed E)Other _____
7. What is the last grade of school you completed? A)High School B)Some College C)College degree
8. What **do you/did you** do for a living? _____ Are you retired? A) Yes B) No
9. How many hours **per week** on average **do you/ did you** work?_____Hrs.
10. What does/did your spouse do for a living? A)Retired B)Disabled C)Homemaker D)Other_____
11. Are you sexually active? A)Yes B)No C)Sexual dysfunction
12. Who do you live with? A)Live Alone B)Spouse C)Parents D)Spouse & Children E)Children F)Caregiver G)Assisted Living/Nursing Home Resident G)Other_____
13. Do you use your seatbelt in the car? A)Never B)Sometimes C)Most of the time D)Always
14. Where were you born? (specify state) _____

Family History

Please fill out, both parents, any siblings and add in any other family members with known medical problems:

RELATIONSHIP	CURRENT AGE NOW OR AGE WHEN DECEASED	YEAR DECEASED	MEDICAL OR HEART PROBLEMS
FATHER		Y N	
MOTHER		Y N	
		Y N	
		Y N	
		Y N	
		Y N	
		Y N	
		Y N	

Review of Symptoms

Have you had any of the following problems or symptoms recently? (Please circle all that apply)

General:
Feels well, Fatigue, Weight Loss, Weight Gain, Appetite Loss, Appetite Gain

Integumentary:
Hair Loss, Dry Skin, Rash, Skin Cancer, Mole Change, Nail/Skin/Hair Changes

Eyes:
Vision 20/20, Glasses/Contacts, Glasses (Reading Only), Legally Blind, Discharge, Pain Glaucoma, Blurred Vision, Macular Degeneration, Double Vision, Color Blindness

Ears, Nose, Mouth, Throat:
Hearing Loss: Partial or Complete, Hearing Aids, Vertigo, Hoarseness, Difficulty Speaking, Sinusitis

Respiratory:
History of Asthma, COPD, Emphysema, Dyspnea (Short of Breath): At Rest or With Exertion,
Cough: Dry or Productive, Frequent Napping, Sleep Apnea, Snoring, Wheezing

Cardiovascular:
Chest Pain, Palpitations, Edema (swelling) - Where do you swell?: _____

Gastrointestinal:
Abdominal Pain, Constipation, Diarrhea, Nausea, Change in Bowel Habits

Genitourinary General:
Dysuria (Painful Urination), Frequency, Hematuria (Blood in Urine), Nocturia, Urgency, Chronic UTI

Female Genitourinary: Regular Periods, Heavy Menstrual Flow, Hot Flashes, Menopausal: Natural or Surgical

Male Genitourinary: History of BPH, Prostate Cancer, Impotence, Decrease Libido

Musculoskeletal:
Arthritis of the: _____, Muscle Pain or Cramps, Loss of Strength, Back Pain, Gout

Neurological:
Confusion, Dementia, Dizziness, Headaches, Memory Loss, TIA, Numbness - Where?: _____

Psychiatric:
Anxiety, Change in Behavior, Depression, Stress, Sleep Disturbance, Thoughts of Suicide

Endocrine:
Fatigue, Hyperlipidemia**,** Hypothyroidism, Hyperthyroidism, Diabetes: Non-Insulin Dependent or Insulin Dependent, Intolerance to Heat, Intolerance to Cold

Hematological/Immunologic:
Bleeding Disorders, Easy Bruising, Vit B-12 Deficiency, Seasonal Allergies, Medical Allergies, Food Allergies

Symptoms: Are you having any of the following symptoms?

Cramping in hip, thigh, or calf	Yes	No
Leg numbness or weakness	Yes	No
Coldness in your feet	Yes	No
Sores on your toes, feet, or legs that won't heal	Yes	No
No pulse or a weak pulse in your legs or feet	Yes	No
Erectile dysfunction in men.	Yes	No