THE TEXAS HEART INSTITUTE®
CENTER FOR CARDIOVASCULAR CARE

PO Box 20345 Houston, Texas 77225-0345
Phone: (832) 355-4900 • Fax: (832) 355-3770
www.texheartsurgeons.com

Cardiovascular Surgery
Jennifer R. Cozart, MD
Charles H. Hallman, MD
James J. Livesay, MD

PATIENT HISTORY QUESTIONNAIRE

Please complete and bring this form with you to your first appointment

Name: _____ Date of Visit: _____

Date of Birth: _____ Referring Health Care Provider: _____

YOUR CONTACT INFORMATION:

Home phone: _____ Cell phone: _____

Email address: _____

HISTORY OF PRESENT ILLNESS (HPI):

Purpose of today's visit: _____

_____

Location: _____
(Where on the body symptom occurs)

Duration: _____
(How long have you had symptom? How long does it last?)

Severity: _____
(Severe, worse, slightly. Pain scale 1-10)

Quality: _____
(Character of symptom...burning, gnawing, stabbing)

Timing: _____
(When symptoms occur)

Context: _____
(Situation associated with symptom)

Modifying Factors: _____
(What things make symptoms better or worse)

Associated Signs/Symptoms: _____
(Other things that happen when this symptom occurs)

PAST MEDICAL HISTORY:

Please place a mark beside those that apply to you:

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Respiratory Problems
- ❑ Stroke
- ❑ Heart Trouble
- ❑ Bleeding Problems
- ❑ Increased Cholesterol
- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Stomach Ulcers
- ❑ Anemia
- ❑ Seizures
- ❑ Thyroid Problems
- ❑ Blood Clots
- ❑ HIV/AIDS
- ❑ Intestinal Bleeding
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Pnemonia/TB
- ❑ Arthritis
- ❑ Gout

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LUNG HISTORY:

Please place a mark beside those that apply to you:

Pulmonary Symptoms:

- ❑ Shortness of Breath
- ❑ Non-productive Cough
- ❑ Wheezing
- ❑ Productive Cough
- ❑ Bloody Sputum

Use of Pulmonary Treatments:

- ❑ Inhalers
- ❑ Steroids
- ❑ Immunosuppressive Drugs
- ❑ Nebulizers
- ❑ Home oxygen

Exposures:

- ❑ Asbestos
- ❑ Sick contacts
- ❑ Travel Outside of US
- ❑ Tuberculosis

History of:

- ❑ Lung mass
- ❑ Lung nodule
- ❑ Lung scar on x-ray

PAST SURGICAL HISTORY:

List all the surgeries you have had in the past (most recent first)

Year: _____ Surgery: _____ Hospital: _____

Year: _____ Surgery: _____ Hospital: _____

Year: _____ Surgery: _____ Hospital: _____

Year: _____ Surgery: _____ Hospital: _____

Year: _____ Surgery: _____ Hospital: _____

PAST FAMILY HISTORY:

Please list any medical problems in your relatives

Father: _____

Mother: _____

Brothers: 1. _____ 2. _____ 3. _____ 4. _____

Sisters: 1. _____ 2. _____ 3. _____ 4. _____

Others: 1. _____ 2. _____ 3. _____ 4. _____

PAST SOCIAL HISTORY:

Please place a mark beside those that apply to you

Marital Status:

- ❑ Single
- ❑ Separated
- ❑ Widowed
- ❑ Married
- ❑ Divorced

Occupation: _____ **Other** _____

Tabacco Use:

- ❑ Yes
- ❑ No
- ❑ Never
- ❑ Quit

Smoker/How Much? _____ Quit/When? _____

Duration in years: _____

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PAST SOCIAL HISTORY (continued):

Please place a mark beside those that apply to you

Alcohol Use:

❑ Yes ❑ No ❑ Never

How Often?

❑ Rarely ❑ Moderate ❑ Daily How Much? _____

Drug Use:

❑ Yes ❑ No ❑ Never Type/frequency? _____

Psychiatric/Behavioral Issues: _____

REVIEW OF SYMPTOMS:

Please place a mark beside those that apply to you

Constitutional:

❑ Fever ❑ Weight Loss ❑ Anorexia ❑ Visual changes

Ear, Nose and Throat:

❑ Hearing loss ❑ Ear ache ❑ Sinus drainage ❑ Sore Throat
❑ Frequent Nose Bleeds

Cardiac:

❑ Chest Pain
❑ Palpitations
❑ Shortness of Breath on Exertion (DOE)
❑ Shortness of Breath at Night (PND)
❑ Pain in legs while walking (Claudication)
❑ Dizziness
❑ Fainting (Syncope)
❑ Transient Visual Loss (Amaurosis Fugax)

Gastroentestinal:

❑ Abdominal pain
❑ Gastroesophageal Reflux Disease (GERD)
❑ Inability to swallow (Dysphagia)
❑ Diarrhea/Constipation
❑ Vomiting blood (Melena)
❑ Bright red blood per rectum (BRBPR)

Urological:

❑ Painful urination (Dysuria)
❑ Urgency of urination
❑ Incontinence
❑ Renal Insufficiency

Musculoskeletal:

❑ Muscle Aches ❑ Cramps ❑ Weakness

Respiratory:

❑ Cough ❑ Wheeze ❑ Shortness of Breath (SOB)

Skin:

❑ Rash ❑ Skin Ulcers ❑ Itching ❑ Breast Pain
❑ Breast Mass

Neurological:

❑ Stroke ❑ Weakness ❑ Numbness ❑ Mental Status Change
❑ Transient Ischemic Attack (TIA)

Psychiatric:

❑ Mood swings ❑ Depression ❑ Anxiety/Panic ❑ Seizures

Endocrine:

❑ Hypothyroid ❑ Hyperthyroid ❑ Diabetes ❑ On Steroids

Hematologic:

❑ Anemia
❑ Easy Bruising
❑ Enlarged lymph nodes
❑ Bleeding tendency (Bleeding diathesis)

Immunologic: Allergies: _____

Frequent Illnesses: _____

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CARDIOVASCULAR HISTORY:

Please write the date of each event that applies to you.

Heart Attack: _____
Angioplasty or Stent: _____
Coronary Artery Bypass Surgery: _____
Congestive Heart Failure: _____
Atrial Fibrillation: _____
Pacemaker/Defibrillator: _____
Ablation Procedure: _____
Valve Problems/Surgery: _____
Heart Murmur: _____
Leg artery blockage/amputation: _____
Kidney artery blockage: _____
Stroke, mini-stroke or TIA: _____
Carotid Artery Surgery: _____
Enlarged aorta/aneurysm: _____
Other: _____

CURRENT MEDICATIONS:

Please list all medications, vitamins, and supplements that you take below. Please make sure your list is accurate and up to date. If you have an up to date and readable copy of your medication list, you may bring that with you instead of filling out this form:

	Name of Medication	Dose	How often?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			

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ALLERGIES:

	Name of Medication	What happened?	When?
1.			
2.			
3.			
4.			
5.			
6.			

COMMUNICATION:

What language do you speak?: _____

Would you like an interpreter? ❑ Yes ❑ No

EMERGENCY CONTACT:
Name of a friend or relative not living with you.

Last Name: _____ First Name: _____ MI: _____

Phone #: _____ (Home) _____ (Mobile) Relation: _____

PATIENT STATEMENT:

To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date: _____