HeartCare Initial Patient History: date ____________________________

Name____ Date arrival in L.A. ____________________
Age _____ Date of birth___/____/______ Birth Place____________________ Ethnicity____________________
Referred by______________________________ Reason for referral ____________________________________
PCP______________________________ Other Physicians & specialty ____________________________________

Chiropractor_________________ Acupuncture____________________ Other____________________________
Occupation/retired (date) ____
Marital status: single married separated divorced widowed partnered
Highest education: grade school high school. College: major. Graduate (field, degree) _________________
Do you use the Internet for medical information: Y N
Reports should be sent to whom? ____

Cardiovascular History (circle, date)

Abnormal EKG	Chest pain/pressure
Heart attack	Shortness of breath
Coronary stents	Severe ankle swelling
Coronary Bypass surgery	Palpitations
Pacemaker	Stroke/TIA
Rhythm ablation/monitor	Diabetes/gestational
Carotid artery disease /surgery/stent	Congestive heart failure
Aneurysm	Ovarian cysts/POS/menopause
Body/Heart scan	Erectile dysfunction
High cholesterol	Chronic arthritis/rheumatoid/lupus/psoriasis
Murmur/heart valve disease	Gout/high uric acid
Echocardiogram/carotid US	High blood pressure
Stress test	Deep vein thrombosis
Chest x-ray	Endometriosis
Pregnancy-related hypertension	Menopause (age, year)
Calf pain when walking	Kidney disease
Lipoprotein (a) carrier	High sugar/diabetes
Sleep apnea/CPAP	Chronic inflammatory diseases/HIV

Current exercise: type, duration, frequency/minutes per week ______________________________________

Stress: grade 1-10: home______ Work______ School_________ Work hours______ Noisy environment Y N

Average sleep duration ___________ Naps (no. Duration) ___________

Circle stress relievers: exercise meditation yoga others: ____

Exercise: what kind, how often, how long______________________________ **Weight goal**: ____________________

Eating: who cooks? _________________ Diet: unrestricted? Other: ______________________________________
Where do you eat breakfast__________ Lunch_________________ How often do you eat out________________

Smoking history includes cigarettes, cigars, chewing tobacco, electronic.
Current smoker? Y/N. Age started: ___________ Packs/day________________ # years_____________________
Past smoker? Y/N. Year quit________________. Exposed to second hand smoke? Y N

Drinking history includes all alcoholic beverages (beer, wine, hard liquor, mixed).
Current drinker: Y/N. #Drinks per week _________________________. Age started__________________
Past drinker: Y/N. Previous consumption: # per week/month/year ______________. Year quit _____________

Caffeine consumption (coffee, tea, chocolate, Coke, Pepsi, others): #per day_____________________________

Recreational drug use: what/when____

 Name: ____

Current Medications and strengths: include prescriptions, over-the-counter supplements, herbs, vitamin steroids, testosterone, hormones and frequency:

Discontinued medications and why: ____

Current and past medical problems (circle & date): cancer, anemia, asthma, cough, cataracts, glaucoma, chronic fatigue, indigestion, colitis, bronchitis, TBC, urinary, insomnia, AIDS, sinusitis, headaches, heartburn, emphysema (COPD), hepatitis, diarrhea, phlebitis, prostate, thyroid, seizures, ulcers, constipation, depression/anxiety, kidney stone/infection, liver disease, nausea/vomiting, psychiatric illness. Others____
Injuries, fractures, concussions____
Surgeries: ____
Hospitalizations: ____

Family history - Indicate heart attack, coronary bypass graft or stent, stroke/TIA, diabetes, organ transplant.

Family Members	Living Age	Illness(es)	Deceased Age	Cause of death
Father				
Mother				
Paternal Grandparents				
Maternal Grandparents				
Brothers				
Sisters				
Daughters				
Sons				
Paternal Aunts, Uncles, Cousins				
Maternal Aunts, Uncles, Cousins				
Husband/wife				