

## EAST TENNESSEE CARDIOVASCULAR SURGERY GROUP, P. C.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Full Last Name, First Name, MI, Maiden Name)

**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_  
 \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security No:** \_\_\_\_-\_\_\_\_-\_\_\_\_

**Sex:** Male – Female \_\_\_\_\_ **Single** \_\_\_\_\_ **Married** \_\_\_\_\_ **Widowed** \_\_\_\_\_ **Divorced** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Telephone:** \_\_\_\_-\_\_\_\_-\_\_\_\_

**Spouse:** \_\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Spouse's Employer:** \_\_\_\_\_ **Telephone:** \_\_\_\_-\_\_\_\_-\_\_\_\_

**Notify In Case Of Emergency Other Than Spouse:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Referring Doctor's Name:** \_\_\_\_\_

**Family Doctor's Name:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Telephone:** \_\_\_\_-\_\_\_\_-\_\_\_\_

\*\*\* If Insurance Coverage is through spouse, we must have spouse's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### INSURANCE INFORMATION

Insurance Company	Insurance Company
Address	Address
Insured's Name	Insured's Name
Policy #	Policy #
Group #	Group #
Effective Date of Coverage	Effective Date of Coverage

# MEDICAL HISTORY

## DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

### CIRCLE YOUR ANSWER

Chest pain (if yes, describe) Yes    No

How Often ? \_\_\_\_\_

What causes the pain? \_\_\_\_\_

What relieves the pain? \_\_\_\_\_

Shortness of breath Yes    No

What activities cause this? \_\_\_\_\_

Does this occur at rest? ..... Yes    No

Does this occur at night? ..... Yes    No

Leg swelling ..... Yes    No

Leg pain from walking ..... Yes    No

How far? \_\_\_\_\_

Cough ..... Yes    No

Sputum/phlegm with cough ..... Yes    No

Blood with cough ..... Yes    No

Fever ..... Yes    No

Weight loss ..... Yes    No

Night sweats ..... Yes    No

Allergies ..... Yes    No

Allergic to: \_\_\_\_\_

Describe reaction: \_\_\_\_\_

List medications, including non-prescription drugs (headache/stomach pills, etc.) and how many times a day.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

(If more space needed, use back of page)

## PAST MEDICAL HISTORY

List all previous surgeries and approximate dates:

List any previous hospitalizations and approximate dates including: heart catheterization, medical illness, pregnancies, accidents.

### HAVE YOU EVER HAD THE FOLLOWING CONDITIONS?

Heart Attack .....	Yes	No
High blood pressure .....	Yes	No
Abnormal cholesterol .....	Yes	No
Irregular heartbeat .....	Yes	No
Leaky valves in the heart .....	Yes	No
Heart murmur .....	Yes	No
Stroke .....	Yes	No
Diabetes .....	Yes	No
Excessive bleeding .....	Yes	No
Blood clots .....	Yes	No
Varicose veins in legs .....	Yes	No
Asthma/emphysema .....	Yes	No
Pneumonia .....	Yes	No
Cancer .....	Yes	No
Anemia (low blood count) .....	Yes	No
Arthritis .....	Yes	No
Hepatitis .....	Yes	No
Blood transfusion .....	Yes	No

Have you ever had a bad reaction to anesthesia? ..... Yes No

If Yes explain: \_\_\_\_\_

### FAMILY HISTORY

Has any family member (parents, grandparents, brothers, sisters, children) had any of the following conditions:

High blood pressure	Yes	No
Heart disease	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Cancer	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Bleeding problems	Yes	No

### SOCIAL HISTORY

Do you now or have you ever used tobacco? Yes No

Cigarettes Yes No

Number of years: \_\_\_\_\_

Number of packs per day: \_\_\_\_\_

Pipe Yes No

Cigar Yes No

Chewing tobacco Yes No

Currently drink alcoholic beverages? Yes No

Beer Yes No

How much in a typical week: \_\_\_\_\_

Wine Yes No

How much in a typical week: \_\_\_\_\_

Liquor Yes No

How much in a typical week: \_\_\_\_\_

Have you ever had problems or counseling for alcohol or habit

forming drugs?	Yes	No
Do you drink coffee?	Yes	No
How much per day: _____		
Tea:	Yes	No
How much per day: _____		
Colas/soft drinks with caffeine:	Yes	No
How much per day: _____		

### OCCUPATION INFORMATION

Current occupation: \_\_\_\_\_

If retired what was your occupation: \_\_\_\_\_

Number of years at this occupation: \_\_\_\_\_

### DOES YOUR JOB INVOLVE

Lifting objects greater than 25 lbs.	Yes	No
Walking more than 100 yards	Yes	No
Climbing more than 10 steps	Yes	No
Driving more than 1 hour at a time	Yes	No
Do you regularly participate in any activities that you would consider Strenuous (yard work, sports, hobbies)	Yes	No

### REVIEW OF SYSTEMS

Weight loss/gain over 10 lbs. in the past year	Yes	No
How much loss/gain: _____		
Sudden vision loss either eye	Yes	No
Sudden loss of speech	Yes	No
Sudden weakness/numbness on one side of the body	Yes	No
Which side:           Right or Left		
Indigestion/heartburn	Yes	No
Intolerance to foods	Yes	No
Explain: _____		
Trouble with urination	Yes	No
Difficulty getting started	Yes	No
Get up more than twice at night	Yes	No
Bleeding/pain with urination	Yes	No
Kidney stones	Yes	No

<b>Constipation</b>	<b>Yes</b>	<b>No</b>
<b>Diarrhea</b>	<b>Yes</b>	<b>No</b>
<b>Bleeding with bowel movements</b>	<b>Yes</b>	<b>No</b>
<b>Joint pain or swelling</b>	<b>Yes</b>	<b>No</b>

**Explain:** \_\_\_\_\_

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**Patient's Signature**

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**Date**