NEW PATIENT (ADULT) HEALTH HISTORY

Cardiac Electrophysiology of Alabama
Nada Memon, MD, FACC, FHRS
701 Univ. Blvd., East, Suite 809, Tuscaloosa, AL 35401
Phone: (205) 759-6921 Fax: (205) 759-6922

TODAY'S DATE: ____________________

Reason for today's visit: ____________________

Preferred pharmacy for prescriptions?

____

PAST MEDICAL HISTORY: (Please check any condition(s) that you have currently or have ever had in the past.)

Cardiovascular

- ○ Abdominal aortic aneurysm
- ○ Ablation
- ○ Anemia
- ○ Angina
- ○ Aortic stenosis
- ○ Atrial fibrillation
- ○ Blood clots
- ○ Carotid stenosis
- ○ Complications after cardiac procedures (specify):

____
____
____
____
____
____
____

- ○ Congestive Heart Failure
- ○ Coronary artery bypass surgery (CABG)
- ○ Coronary artery disease
- ○ Coronary artery stents
- ○ Defibrillator (ICD)
- ○ DVT(Deep Vein thrombosis)
- ○ Endocarditis
- ○ EP study
- ○ Fainting
- ○ Heart attack/MI
- ○ High blood pressure
- ○ High cholesterol
- ○ Hypertrophic obstructive cardiomyopathy (HOCM)
- ○ Irregular heart beat
- ○ Mini-strokes
- ○ Mitochondrial disease
- ○ Near syncope
- ○ Pacemaker placement
- ○ Palpitations
- ○ PE (Pulmonary embolism)
- ○ Peripheral vascular disease or stents
- ○ Skipped beats
- ○ Stroke
- ○ Syncope
- ○ TIA(Transient Ischemic Attack)
- ○ Valve disease

Derm

- ○ Abscesses
- ○ Melanoma
- ○ Psoriasis
- ○ Skin cancer (specify) ____________

____

Endocrine

- ○ Diabetes, on insulin
- ○ Diabetes, on pills
- ○ Diabetes, type 1
- ○ Diabetes, type 2
- ○ Diabetic neuropathy
- ○ Gout
- ○ High blood sugar
- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Thyroid problems

GI

- ○ Cirrhosis
- ○ Colon cancer
- ○ Crohn's Disease
- ○ Diverticulosis
- ○ GERD (reflux)
- ○ GI bleeding
- ○ Hiatal hernia
- ○ Irritable Bowel Syndrome
- ○ Liver disease
- ○ Pancreatitis
- ○ Peptic Ulcer Disease
- ○ Stomach ulcer
- ○ Ulcerative Colitis

GU

Male

- ○ BPH (Benign prostatic hypertrophy)
- ○ Blood in urine
- ○ Epididymitis
- ○ Inguinal hernia
- ○ Prostate cancer
- ○ Prostatitis

Female

- ○ Blood in urine
- ○ Dysmenorrhea

HEENT

- ○ Glaucoma
- ○ Hearing deficit
- ○ Vision deficit

Infections

- ○ Hepatitis
- ○ HIV/AIDS
- ○ Syphilis
- ○ Tuberculosis/TB

Musculoskeletal

- ○ Arthritis
- ○ Rotator cuff tear

Neuro/Psych

- ○ ADHD
- ○ Alcohol abuse
- ○ Alzheimer's disease
- ○ Anxiety
- ○ Autism
- ○ Bipolar disorder
- ○ Brain cancer
- ○ Dementia
- ○ Depression
- ○ Eating Disorder
- ○ Fibromyalgia
- ○ Headaches
- ○ Migraines
- ○ Parkinson's disease
- ○ Schizophrenia
- ○ Seizures
- ○ Substance abuse

Renal

- ○ Dialysis
- ○ Fistula/Location (specify)

____

- ○ Peritoneal
- ○ Renal cancer
- ○ Renal failure or insufficiency

Respiratory

- ○ Asthma
- ○ COPD
- ○ CPAP use
- ○ Emphysema
- ○ Lung cancer
- ○ Oxygen use
- ○ Sleep apnea

Cancer (specify)

- ○ Type: ____________
  ____
  ____
- ○ Port location: ________
  ____
  ____
- ○ Chemotherapy:
  Dates: ____________
  Type: ____________
  ____
  ____
- ○ Radiation:
  Location: ____________
  ____
  ____

Other

- ○ ____________________
- ○ ____________________
- ○ ____________________
- ○ ____________________
- ○ ____________________
- ○ ____________________

FOR WOMEN:

Last menstrual cycle?

____

Age at menopause?

____

Do you desire to get pregnant?____________

Birth control use? Y / N

New Patient (Adult) Health History

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TODAY'S DATE: ____________________

	Date
Last flu vaccination	
Last Pneumonia shot	
Last Mammogram	
Last Pap Smear	
Last Colonoscopy	

Date of last Blood work: ____________ Sample taken at Dr. ____________ or Lab ____________

CURRENT MEDICATIONS (prescriptions AND over-the-counter/herbals)

Medication	Dose	Frequency	Who prescribed this medication?

Drug Allergies (please list your reaction to each drug): ____________________

Food/latex/other allergies: ____________________

Chemotherapy: ☐ Yes/No **Radiation:** ☐ Yes/No **Steroids:** ☐ Yes/No

HOSPITALIZATIONS / SURGERIES / INJURIES:

Year	Name of illness/operation/injury

SPECIALISTS: What specialists do you see? (for example: cardiologist, internist, nephrologist, etc.)

Name of Doctor/Practice	Specialty	Condition for which they treat you

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FAMILY HISTORY: (Please check if any of your blood relatives have had any of the following:)

Heart problems:
- ○ Atrial Fibrillation
- ○ Congestive heart failure
- ○ Coronary disease
- ○ Electrophysiology study/Ablation
- ○ High cholesterol
- ○ High blood pressure
- ○ Implantable cardiac defibrillator (ICD)
- ○ Pacemaker
- ○ Valve disease
- ○ Wolff-Parkinson-White Syndrome (WPW)

Genetic history:
- ○ Family history of known genetic condition
- ○ Family history of mitochondrial disease
- ○ Family history of sudden cardiac/unexplained death

- ○ Alcoholism
- ○ Asthma
- ○ Atherosclerosis
- ○ Autoimmume disease
- ○ Blood disorder
- ○ Dementia
- ○ Depression
- ○ Diabetes mellitus
- ○ Drug abuse
- ○ Hearing problems

- ○ Hepatitis B
- ○ Kidney disease
- ○ Mental illness
- ○ Obesity
- ○ Rheumatoid disease
- ○ Stroke
- ○ Thyroid disease
- ○ Tuberculosis
- ○ Vision problems
- ○ Other: ____________

List all family members and ages:

Relation	Current age or "D" if deceased	Health Problems/Cause of Death
Mother		
Father		
Siblings:		
Children:		

HEALTH HABITS:

	Use daily	Use weekly	Use rarely	Do Not Use	Have used in past, but not now
Alcohol					
Caffeine					
Drugs					
Tobacco					
Herbal supplements					
Other					

Exercise (type and frequency): ______________________________

Diet preferences or restrictions (e.g., gluten-free, vegan, etc.): ______________________________

Spiritual beliefs/preferences: ______________________________

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Please check all of the symptoms that you are currently experiencing or have had in the last 6 months.

CONSTITUTIONAL	○ Appetite change ○ Excessive sweating ○ Fatigue	○ Fever ○ Night sweats	○ Weight gain ____ lbs ○ Weight loss ____ lbs
EYES	○ Blurred vision ○ Wear glasses or contacts ○ Double vision	○ Eye irritation ○ Eye pain	○ Spots in vision ○ Vision loss
EARS, NOSE, MOUTH, THROAT	○ Ear pain ○ Hearing loss ○ Ringing m ears ○ Facial pain ○ Runny nose	○ Nasal obstruction ○ Nose bleeds ○ Post-nasal drainage ○ Bleeding gums	○ Dental pain ○ Mouth lesions ○ Hoarseness ○ Sore throat
CARDIOVASCULAR	○ Chest pain ○ Decreased exercise tolerance ○ Difficulty breathing with exertion	○ Difficulty breathing when lying flat ○ Sleep on more than 1 pillow ○ Palpitations/irregular heartbeat	○ Fainting/passing out ○ Leg pain with walking ○ Leg ulcers ○ Swollen feet/ankles
RESPIRATORY	○ Cough ○ Sputum (phlegm) production ○ Coughing up blood	○ Shortness of breath ○ Chest pain with deep breathing	○ Wheezing ○ Snoring ○ Sleep apnea
GASTROINTESTINAL	○ Abdominal pain ○ Bloating ○ Food intolerance (explain): ____________	○ Nausea ○ Vomiting ○ Trouble swallowing ○ Reflux/heartburn	○ Change in bowel habits ○ Constipation ○ Diarrhea ○ Black stools ○ Bloody stools
GENITOURINARY	○ Change in urinary stream ○ Pain with urinating ○ Blood in urine ○ Incontinence ○ Awakening at night to urinate	○ Frequent urination	○ Post-menopausal ○ Frequent UTIs
MUSCULOSKELETAL	○ Back pain ○ Joint pain ○ Joint swelling	○ Limited range of motion ○ Muscle aches ○ Muscle weakness	○ Stiffness
INTEGUMENTARY	○ Lesions	○ Rash	○ Breast masses ○ Breast skin changes
NEUROLOGIC	○ Abnormal gait ○ Weakness of a particular body part (not overall weakness) ○ Headache	○ Incoordination ○ Memory problems ○ Numbness ○ Seizures	○ Slurred speech ○ Tremor ○ Dizziness or vertigo
PSYCHIATRIC	○ Anxiety ○ Decreased concentration	○ Irritability ○ Panic attacks	○ Sleep disturbances ○ Sadness/tearfulness
ENDOCRINE	○ Increased thirst ○ Increased appetite	○ Urinating frequently and large amount	○ Hot-natured ○ Cold-natured ○ Abnormal menstrual pattern
HEMATOLOGIC/LYMPHATIC	○ Easy bruising ○ Easy bleeding	○ Recurrent infections ○ Swollen lymph nodes	
ALLERGIC/IMMUNOLOGIC	○ Eczema	○ Seasonal allergies	○ Hives

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