PREMIER HEART GROUP

121 St. Lukes Center Dr.
Suite 501
Chesterfield, MO 63017

HEALTH HISTORY

Patient Name:_____ Birthdate:_____/_____/_____ Date:_____

PATIENT MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Diabetes	No	Yes	_____	Convulsions	No	Yes	_____
Hypertension	No	Yes	_____	Bleeding tendency	No	Yes	_____
Cancer	No	Yes	_____	Acute Infections	No	Yes	_____
Stroke	No	Yes	_____	Venereal disease	No	Yes	_____
Heart trouble	No	Yes	_____	Hereditary defects	No	Yes	_____
Arthritis/gout	No	Yes	_____				

Previous Hospitalizations / Surgeries / Serious Injuries: Date:_____

_____
_____
_____

Please list all medicines you are currently taking (Include non-prescription drugs):

_____
_____
_____
_____

PATIENT SOCIAL HISTORY

Marital status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Use of alcohol: Never_____ Rarely_____ Moderate_____ Daily_____

Use of tobacco: Never_____ Previously, but quit_____ Current packs/day_____

Use of drugs: Never_____ Type/Frequency_____

Occupation: _____

Excessive exposure at home or work to: Fumes_____ Dust_____ Solvents_____ Air-borne particles_____ Noise_____

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

OVER

CONSTUTUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoria	No	Yes
Palpitation	No	Yes
Shortness or breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes
Hypertension	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or deuodenal)	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male-testicle pain	No	Yes
Female pain with periods	No	Yes
Female irregular periods	No	Yes
Female vaginal discharge	No	Yes

Female # of pregnancies_____# of miscarriages_____
Female date of last pap smear_____

If you answered yes explain_____
_____

MUSCULOSKELETAL

Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

INTEGUMENTARY (SKIN, BREAST)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast discharge	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptic	No	Yes

Other drugs/medications_____
Know food allergies_____

If you answered yes explain_____
_____