



Cheshire Medical Center Dartmouth-Hitchcock Keene

580-90 Court Street, Keene, NH 03431

Cardiology Department
Medical History Form

Today's Date: _____

Name: _____

DOB: _____

Reason for today's visit:

List All Current and Past Health Problems including chronic conditions (diabetes, high blood pressure, etc., surgeries and hospitalizations.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

List All Medications You are currently taking
Include Non-Prescription meds and Birth Control:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

List All Allergies to Meds and Reaction:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Family History:

History of heart disease in parents, siblings or children? If yes, please explain:

If parents, siblings or children are deceased, please state age and cause of death:

Social History:

Marital Status? Married Single Divorced Widow/Widower

Children? _____ if yes, how many at home? _____

Do you live alone? Yes No

Do you currently smoke? Yes No Packs per day _____ Years _____

Did you smoke in the past? Yes No Packs per day _____ Years _____

Do you drink alcohol? Yes No Amount per week _____

Current/past occupation _____

List previous occupations (from first to most recent)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Review of Systems:

Do you suffer from or have difficulty with any of the below listed symptoms?
(Check specific problem if more than one are listed together.)

Constitutional:

- Weight Loss
- Weight Gain
- Fevers

Eyes:

- Glasses
- Changes in Vision
- Blindness (permanent or temporary)

Ears, Nose Throat:

- Loss of hearing
- Difficulty swallowing
- Recent major dental work or infections

Cardiovascular:

- Chest Pain
- Palpitations or irregular heartbeat
- Pain in legs with exercise
- Swelling in ankles
- Fainting
- Shortness of breath

Respiratory:

- Cough
- Wheezing
- Coughing up blood
- Shortness of breath

Gastrointestinal:

- Abdominal pain
- Nausea or vomiting
- Constipation
- Diarrhea
- Vomiting blood or blood in stool
- Esophageal reflux/heartburn

Genitourinary:

- Pain with urination
- Blood in urine
- Urinating at night

Musculoskeletal:

- Arthritis
- Back Pain
- Swollen joints

Skin:

- Rashes
- Sores
- Breast discharge

Neurologic:

- Weakness
- Stroke or mini stroke
- Dizzy spells
- Headache

Psychiatric:

- Depression
- Anxiety

Endocrine:

- Frequent Urination
- Excess Thirst
- Heat or Cold intolerance

Hematological/Lymphatic:

- History of excessive bleeding
- History of blood clots
- Swollen Lymph nodes

Allergic/Immunologic

- Frequent Infections
- Food Allergies
- Environmental Allergies