MINNEAPOLIS HEART INSTITUTE®

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Patient Label

NAME: _____ **DATE:** _____

Date of Birth: _____ **Male** _____ **Female**____

Address: _____

City, State and Zip: _____Telephone: _____

Phone Number: _____ Alternate Phone Number: _____

Your Primary Physician: _____

Address: _____

City, State and Zip: _____Telephone: _____

Physician who referred you today (if different from Primary Physician):_____

Address: _____

City, State and Zip: _____Telephone: _____

Your Primary Cardiologist at MHI: _____

Reason for visit today: _____

HISTORY OF PRESENT ILLNESS

1. Have you had chest discomfort? Yes ☐ No ☐
   If no, skip to Question #2.
   If yes, please answer the following:
   A. When did you first experience chest discomfort? _____
   B. How frequently does the chest discomfort occur? (CHECK ONE)
      ☐ Once a day ☐ Once a month
      ☐ Once a week ☐ More frequently
   C. Check the following words that describe your chest discomfort:
      ☐ Sharp ☐ Burning ☐ Tightness
      ☐ Stabbing ☐ Fullness ☐ Crushing
      ☐ Aching ☐ Pressure
   D. Does this discomfort radiate from your chest to:
      ☐ Right arm ☐ Jaw ☐ Right shoulder
      ☐ Left arm ☐ Teeth ☐ Left shoulder
      ☐ Neck ☐ Throat ☐ Back
   E. What activities bring on this discomfort? _____
      _____
   F. Have you experienced this discomfort at rest? Yes ☐ No ☐
   G. How long does this discomfort last?
      ☐ Less than 1 minute
      ☐ 1-5 minutes
      ☐ 30 minutes to 1 hour
      ☐ Longer than 1 hour
   H. What do you do to relieve this discomfort? _____
      _____
   I. Have you ever been hospitalized because of this discomfort? Yes ☐ No ☐
   J. Does this discomfort restrict your activity? Yes ☐ No ☐
   K. On a scale of 0 to 10 rate your chest discomfort (10 being the most intense and 0 being the least intense)
      0 1 2 3 4 5 6 7 8 9 10
2. Do you ever have trouble breathing or do you ever get short of breath?
   ☐ With exertion ☐ At rest ☐ Awake with shortness of breath at night

HISTORY OF PRESENT ILLNESS (continued)

3. Do you have an abnormal heartbeat? Yes ☐ No ☐
   If no, skip to Cardiac Risk Factors.
   If yes, please answer the following questions:

   A. When did you first notice this abnormal heartbeat? Month _____ Year _____

   B. Does your heart beat "too fast"? Yes ☐ No ☐
   Does your heart beat "too slowly"? Yes ☐ No ☐
   Does your heart "skip beats"? Yes ☐ No ☐

   C. Does your heart beat: ☐ Regularly ☐ Irregularly ☐ Don't know
   D. Does this start: ☐ Suddenly ☐ Gradually
   E. Does this stop: ☐ Suddenly ☐ Gradually
   F. How often does this occur? ☐ Daily ☐ Weekly ☐ Other
   G. How long does it last when it occurs? ☐ Seconds ☐ Minutes ☐ Hours ☐ Other
   H. Can you do anything to make it stop? _____

   I. Check any other symptoms that have occurred with it:
   ☐ Pain ☐ Dizziness ☐ Sweaty ☐ Passing out
   ☐ Breathing difficulty ☐ Discomfort ☐ Lightheadedness ☐ Vomiting
   ☐ Sick to stomach ☐ Palpitations ☐ Other symptoms ☐ None

   J. Are there activities, foods, etc. that can bring it on? Yes ☐ No ☐
   If yes, please list: _____
   K. Have you ever been on medication for this problem? Yes ☐ No ☐
   If yes, what were those medications? _____
   L. Did the medication: ☐ Help ☐ Make it worse ☐ No difference ☐ Unsure

   M. Were you ever seen by a physician for this problem? Yes ☐ No ☐
   If yes, was the problem documented on an EKG? Yes ☐ No ☐
   N. Do these occurrences limit your activity or affect your lifestyles? Yes ☐ No ☐

CARDIAC RISK FACTORS

1. Have you ever had elevated cholesterol or blood fats? Yes ☐ No ☐ Unknown ☐
   If yes, give length of time: _____
   If yes, are you taking medication for this? Yes ☐ No ☐ Unknown ☐
   What is the name of this medication? _____
2. Do you have high blood pressure or ever been treated for high blood pressure? Yes ☐ No ☐ Unknown ☐
   If yes, give the length of time: _____
   If yes, are you taking medication to lower your blood pressure? Yes ☐ No ☐ Unknown ☐
   What is the name of this medication? _____
   Do you monitor your blood pressure? Yes ☐ No ☐ Unknown ☐
3. Do you currently smoke, or are you a former smoker? Yes ☐ No ☐ Unknown ☐
   If yes,

Do you smoke cigarettes?	Yes ☐ No ☐
Do you smoke cigars?	Yes ☐ No ☐
Do you chew smokeless tobacco?	Yes ☐ No ☐
# of packs/day (circle)	<1 1 1 ½ 2 or more
# of years smoked	
Year smoking started	
Year smoking stopped	

   Have you ever been given advice to quit smoking? Yes ☐ No ☐ Unknown ☐
4. Have you ever had diabetes? Yes ☐ No ☐ Unknown ☐
   If yes, give length of time: _____

CARDIAC RISK FACTORS (continued)

5. Is there any history of heart disease in your family? Yes ☐ No ☐ Unknown ☐
   (Definition: First-degree male relative under age 55 or female relative under age 65)

6. Do you exercise regularly? Yes ☐ No ☐ Unknown ☐
   If yes, please indicate which activities you routinely participate in and the amount of time:

Activity	Frequency / week	Duration (minutes)
Walk	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Bike	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Swim	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Jog	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Run	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Stairs	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Treadmill	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Nordic Track	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Cardiac Rehab	0 1 2 3 4 5 6 7	<10 <15 30 45 >45

Do you use any home exercise equipment? Yes ☐ No ☐ Unknown ☐
If yes, what equipment do you use? ?_____

7. Do you modify your diet for: sodium (salt) ☐ cholesterol ☐ saturated fat ☐ sugar ☐ calories ☐
8. Do you wish to speak with a dietitian? Yes ☐ No ☐ Unknown ☐
9.

MEDICATIONS

Please list your current medications. Be sure to include any over-the-counter medications, vitamins and herbal/dietary supplements or weight control medications.

NAME	DOSAGE	FREQUENCY

ALLERGIES

1. Do you have any allergies to medications or food? Yes ☐ No ☐
   If yes, which ones: _____

2. Have you ever received contrast or dye for an Xray or test? Yes ☐ No ☐
   If yes, did you have any side effects? Yes ☐ No ☐

3. Have you had asthma? Yes ☐ No ☐
4. Have you had hives? Yes ☐ No ☐
   From what (iodine, shellfish, etc.)? _____

SOCIAL HISTORY

1. Are you retired? Yes ☐ No ☐
   If yes, when did you retire? _____
2. What is/was your occupation(s)? _____
   _____
3. What is the highest level of education you completed?
   Grade school ☐ High school ☐ College ☐ Post Graduate ☐
4. Do you or have you ever-used illicit or street drugs? Yes ☐ No ☐
   If yes, please indicate type: If Yes: Now ☐ In the Past ☐
   - ☐ Marijuana ☐ Cocaine
   - ☐ Amphetamines ☐ Hallucinogens
   - ☐ Sedatives ☐ Weight Loss medications

   _____

5. How much of the following do you consume daily?

	Cups
Caffeine (coffee, colas)	0 1 2 3 4 5 6 or more
Alcohol	0 <1 1 2 3 or more

6. Rank your overall stress level by circling the appropriate number below using a scale from 1-10, 1 being low to minimal stress and 10 being the greatest amount of stress.
   0 1 2 3 4 5 6 7 8 9 10
   Is your stress manageable? Yes ☐ No ☐
   What are your stressors? Family ☐ Occupation ☐ Financial ☐ Medical ☐

FAMILY HISTORY

	Age, if living	Health Status	Age and Cause of Death
Father			
Mother			
Brothers:			
Sisters:			
Spouse:			
Children:			

Do any members of your extended family have heart disease? Yes ☐ No ☐

(Extended family includes: Grandparents, Aunts, and Uncles)

	Age, if living	Health Status	Age and Cause of Death

PAST MEDICAL and SURGICAL HISTORY

Please list any chronic or acute diseases/diagnosis that you have been found to have. Also, list any surgeries that you have undergone.

DIAGNOSIS or SURGERY	DATE

HOSPITALIZATIONS

Have you been hospitalized for any reason? Yes ☐ No ☐

If yes, please describe (begin with the most recent):

REASON	WHERE	DATE

Have you ever had a blood transfusion? Yes ☐ No ☐

Have you ever had a reaction to a blood transfusion? Yes ☐ No ☐

REVIEW OF SYSTEMS

1. *General:*
   Have you been experiencing: ☐ Fever ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Chills ☐ Sweats ☐ Appetite Loss

2. *Eyes*
   Do you have: ☐ Blurred vision ☐ Cataracts ☐ Eye Irritation ☐ Eye redness ☐ Corrective lenses ☐ Glaucoma ☐ Light Sensitivity ☐ Halos around lights ☐ Double Vision ☐ Eye Pain ☐ Eye Discharge ☐ Vision Loss: ☐ One Eye ☐ Both Eyes

3. *Ears/Nose/Throat*
   Do you have: ☐ Decreased hearing ☐ Poor dental hygiene ☐ Ear Discharge ☐ Sore Throat ☐ Hoarseness ☐ Nosebleeds ☐ Difficulty swallowing ☐ Snoring ☐ Ringing in ears ☐ Ear Ache ☐ Nasal Congestion

4. *Cardiovascular*
   Do you have: ☐ Chest pain/discomfort ☐ Leg cramps with exertion ☐ Trouble breathing lying down ☐ Lightheadedness ☐ Palpitations ☐ Trouble breathing at night ☐ Fainting ☐ Swelling of hands or feet ☐ Racing or skipping heart ☐ Bluish Discoloration of nails/lips ☐ Shortness of breath with exertion

REVIEW OF SYSTEMS (continued)

5. *Respiratory*
Do you have: ☐ Asthma ☐ COPD (lung disease) ☐ Coughing up blood ☐ Excessive sputum ☐ Cough ☐ Chest discomfort ☐ Sleep disturbance due to breathing ☐ Wheezing ☐ Shortness of breath ☐ Excessive snoring

6. *Gastrointestinal*
Do you have: ☐ Abdominal pain ☐ Change in bowel habits ☐ Constipation ☐ Gas ☐ Diarrhea ☐ Dark tarry stools ☐ Vomit blood ☐ Heartburn ☐ Yellow skin or eyes ☐ Blood in stool ☐ Nausea ☐ Indigestion ☐ Rectal bleeding ☐ Ulcer disease ☐ Vomiting ☐ Excessive Bloating ☐ Abdominal bloating ☐ Hemorrhoids

7. *Genitourinary*
Do you have: ☐ Pain on urination ☐ Blood in urine ☐ Urinary Urgency ☐ Urinary frequency ☐ Trouble starting stream ☐ Night time urination ☐ Incontinence ☐ Decreased sex drive ☐ Erectile dysfunction ☐ Genital Sores ☐ Unusual color of urine ☐ Inability to empty bladder ☐ Kidney Pain ☐ Pelvic pain ☐ Foul urinary discharge ☐ Missed Periods ☐ Excessively heavy periods

8. *Musculoskeletal*
Do you have: ☐ Arthritis/joint swelling ☐ Stiffness ☐ Gout ☐ Muscle weakness

9. *Skin*
Do you have: ☐ Dryness ☐ Itching ☐ Lesions ☐ Nodules ☐ Open sores ☐ Rash

10. *Neurologic*
Do you have: ☐ CVA (stroke) ☐ Headaches ☐ Tremors ☐ Difficulty with speech ☐ Numbness/tingling ☐ Seizures ☐ Vertigo ☐ Weakness ☐ Dizziness ☐ Memory Loss

11. *Psychiatric*
Do you have: ☐ Anxiety ☐ Depression ☐ Mental Disturbance ☐ Suicidal ideation

12. *Endocrine*
Do you have: ☐ Cold intolerance ☐ Diabetes Mellitus ☐ Heat intolerance ☐ Polydipsia (thirsty) ☐ Polyuria (urination in large amts) ☐ Thyroid disease ☐ Weight change

13. *Heme/Lymphatic*
Do you have: ☐ Abnormal bruising ☐ Bleeding disorder ☐ Clotting disorder ☐ Enlarged lymph nodes

14. *Allergic/Immunologic*
Do you have: ☐ Urticaria (Hives) ☐ Hay fever ☐ Persistent infections ☐ HIV exposure

LEARNING STYLE

1. Identified Learning Barriers:
   - ☐ None
   - ☐ Sensory Problem(s)
   - ☐ Cultural/Religious Practice
   - ☐ Pain
   - ☐ Reading Ability
   - ☐ Emotional State
   - ☐ Other _____

2. Communication Barriers:
   - ☐ Language other than English
   - ☐ Speech/Hearing Impaired
   - ☐ Vision Impaired
   - ☐ Change in memory status
   - ☐ Long Term ☐ Short Term ☐ Immediate Recall

   (immediate = within last hour/Short Term = within week/Long Term = over one year)

3. Preferred Style of Learning:

   What is the easiest way for you to learn?
   - ☐ Listening
   - ☐ Reading
   - ☐ Pictures/Video
   - ☐ Demonstration
   - ☐ Other _____
   - ☐ Needs caretaker to receive education

     Who? _____

RELATIONSHIPS

1. Are you currently involved in any relationships in which you feel unsafe? ☐ Yes ☐ No