HeartPlace®

Arlington Surgery

Dr. Norcross, Cardiothoracic Surgeon
Dr. Hamman, Cardiothoracic Surgeon *Satelite Office*

Date: _____ 20_____

Patient: _____ Birth Date: _____ Age: _____

Whom are you here to see? ____ Dr. Norcross ____ Dr. Hamman

Referring Physician: _____ Primary Care Physician: _____

Oncologist: _____ Pulmonologist: _____

Cardiologist: _____ Gastroenterologist: _____

People present with you: _____

CHIEF COMPLAINT:

Why are you here to see the surgeon today? _____

When was it discovered? _____

How was it discovered and by whom? _____

MEDICATIONS: Please list all the medications you are taking, including over the counter drugs:

Name of medicine	Dose/Strength	Times a day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Patient Name: _____ Date of Birth: _____

Date: _____

ALLERGIES:

Name of Allergen			Reaction/Side Effect	Name of Allergen			Reaction/Side Effect
X-ray contrast	Y	N	_____	Iodine	Y	N	_____
Shellfish	Y	N	_____	Penicillin	Y	N	_____
_____			_____	_____			_____

PROCEDURES:

Physicians' Notes

	Date	Physician
Heart Catheterization (CATH):	_____	_____
Carotid Ultrasound:	_____	_____
CT scan: _____	_____	_____
X-ray: _____	_____	_____
Bone Scan:	_____	_____
PET scan:	_____	_____
Bronchoscopy:	_____	_____
Biopsy: _____	_____	_____
Pulmonary Function Test (PFT):	_____	_____
Barium Swallow:	_____	_____

HISTORY OF PRESENT ILLNESS: Have you had any of the following?

Chest Pain Y N When _____

a. Severity Minimal Mild Moderate Severe Other

b. Onset _____Minutes/Hours/Days/Weeks/Months/Years

c. Status Chronic Improved New No change Resolved Worse

d. Frequency Constant Off & on

_____Time(s) every _____ Minutes/Hours/Days/Weeks/Months/Years

e. Duration _____Seconds/ Minutes/Hours/Days/Weeks/Months/Years or Varies

Carotid artery disease: Y N Date _____

Dizziness: Y N Date _____

Fainting spells: Y N Date _____

Falling episodes: Y N Date _____

Heart attack: Y N Date _____

Heart murmur: Y N Date _____

Irregular heart beat: Y N Date _____

Rheumatic fever: Y N Date _____

Weakness/Numbness: Y N Date _____

Physicians' Notes

Vision changes: Y N Date _____

Stroke: Y N Date _____

Palpitations: Y N Date _____

Patient Name: _____ Date of Birth: _____

Date: _____

RISK FACTORS: Do you have any of the following risk factors?

a. Do you smoke (or have you ever)? Y N Former
Start date _____ Quit date _____ Packs per day _____
Tobacco: Cigarettes Chewing Cigar Pipe Smokeless

b. Diabetes: Type I (Juvenile) Type II (Adult Onset) Year diagnosed _____

c. Dyslipidemia (abnormal cholesterol results): Y N Year diagnosed _____

d. Hypertension (High Blood Pressure): Y N Year diagnosed _____

e. Family history of Coronary Disease (age 60 & under): Y N Who? _____

f. Peripheral vascular disease? Y N

LABS: When was your last lab work? Date: _____ Doctor: _____

PAST MEDICAL HISTORY:

Have you had any of the following?

Exposure to asbestos:	Y	N	Coughing up blood:	Y	N
Mental status changes:	Y	N	Tuberculosis or exposure:	Y	N
Pneumonia:	Y	N	Emphysema:	Y	N
Arthritis:	Y	N	Depression or anxiety:	Y	N
Gout:	Y	N	Chronic Back Pain:	Y	N
Seizure Disorder:	Y	N	Stroke:	Y	N
Thyroid Disorder:	Y	N			
Cancer:	Y	N	Type(s): _____		
	Treatment:		Chemo Radiation Surgery (date) _____		

Please list any other medical conditions:

_____

_____

PAST SURGICAL HISTORY:

	Date		Date
Pacemaker Implant:	_____	Pacemaker Generator Change:	_____
Defibrillator Implant:	_____	Heart surgery – bypass:	_____
Heart surgery – aortic valve:	_____	Heart surgery – mitral valve:	_____
Stent/angioplasty:	_____	Carotid Endarectomy: R L	_____

Please list any other surgeries:

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Date: _____

SOCIAL HISTORY: (Please circle what best applies)

Marital Status? Divorced Separated Married Partner Single Widowed

Do you have children? Y N If yes how many? _____ boys _____ girls

What is your diet? Regular Low fat/chol Low salt Diabetic Renal No added salt
Weight loss Low carb Gluten free Vegetarian Other_____

Do you exercise regularly? Y N Regular Occasional Social Frequent Daily
If formerly, what year did you quit? _____

Can you climb a flight of stairs? Y N If yes, do you get short of breath? Y N
If you can not, what makes you stop? _____

Do you smoke? Y N Formerly Never Type: cigarettes, chewing, cigars, pipe, smokeless
How many packs do (or did) you smoke and how often? _____

Do you drink alcohol? Y N Formerly Never If formerly, what year did you quit? _____
How much did you drink in an average week? 0-1 1-5 6-10 10+

Do you use any recreational drugs? Y N Frequency: _____ If formerly, what year did you quit? _____

What kind of Advanced Directive do you currently have?
None Living Will DNR – Do not resuscitate No life support Power of Attorney

Primary Language: _____ Secondary Language: _____

Residence: Alone With Spouse Family Member Nursing Facility Assisted Living

Recent travel out of the country: Y N Destination: _____

Religious preference? _____ Agree to blood transfusion? Y N

Are you retired? Y N What type of work do (or did) you do? _____

FAMILY HISTORY: (ex: Heart attack, Emphysema, Cancer/Type, Pacemaker, Irregular Heart Beat, Diabetes, Angina)

Member	Problem	Age Diagnosed	Was this cause of death?		
ex- Paternal Grandmother	Stroke	57	Y	N	(Age) 93
_____	_____	_____	Y	N	(Age) _____
_____	_____	_____	Y	N	(Age) _____
_____	_____	_____	Y	N	(Age) _____
_____	_____	_____	Y	N	(Age) _____
_____	_____	_____	Y	N	(Age) _____
_____	_____	_____	Y	N	(Age) _____
_____	_____	_____	Y	N	(Age) _____
_____	_____	_____	Y	N	(Age) _____

Patient Name: _____ Date of Birth: _____

Date: _____

REVIEW OF SYSTEMS: Health problems you have or have had in the past

1. **Constitutional:** Y N
   - a. Weight loss Y N
   - b. Weight gain Y N
   - c. Fever Y N
   - d. Chills Y N
   - e. Fatigue Y N
   - f. Night Sweats Y N

2. **Eyes**:
   - a. Glaucoma Y N
   - b. Cataracts Y N
   - c. Redness Y N

3. **Ears, Nose, Mouth, Throat:**
   - a. Sinusitis Y N
   - b. Hearing loss Y N
   - c. Tooth pain Y N
   - d. Vertigo Y N
   - e. Seasonal Allergies Y N

4. **Respiratory:**
   - a. Wheezing Y N
   - b. Bronchitis Y N
   - c. Chronic cough or sputum Y N
   - d. Shortness of Breath Y N
   - e. Wake up short of breath Y N
   - f. Difficulty breathing- exertion Y N
   - g. Difficulty breathing- laying Y N
   - h. Asthma Y N
   - i. Snoring Y N
   - j. Emphysema Y N
   - k. Tuberculosis Y N
   - l. Pneumonia Y N

5. **Cardiovascular:**
   - a. Chest pain Y N
   - a. Palpitations Y N
   - b. Swelling in extremities Y N
   - c. Sweating Y N
   - d. High blood pressure Y N
   - e. High cholesterol Y N

6. **Gastrointestinal:**
   - a. Heartburn Y N
   - b. Chronic constipation Y N
   - c. Chronic diarrhea Y N
   - d. Gallstones Y N
   - e. Reflux Y N
   - f. Nausea Y N
   - g. Ulcers Y N
   - h. Hiatal Hernia Y N
   - i. Hepatitis Y N
   - j. Diverticulitis Y N

7. **Genitourinary:**
   - a. Urinary Infections Y N
     How often? _____
   - b. Kidney stones Y N
   - c. Blood in urine Y N
   - d. Sexual dysfunction Y N
   - e. Breast: lumps or pain R L Y N

8. **Endocrine:**
   - a. Diabetes Y N
   - b. Thyroid disorder Y N
   - c. Heat/Cold intolerance Y N
   - d. Goiter Y N
   - e. Hair Loss Y N

9. **Neurological:**
   - a. Numbness Y N
   - b. Dizziness Y N
   - c. Fainting Y N
   - d. Stroke Y N
   - e. Balance problems Y N
   - f. Memory loss Y N
   - g. Tremors Y N
   - h. Seizure disorder Y N

10. **Psychiatric:**
    - **a.** Psychosis Y N
    - **b.** Irritable Y N
    - **c.** Mood Swings Y N
    - d. Sleep Problems Y N
    - e. Depression Y N
    - f. Anxiety Y N
    - g. Psychosis Y N

11. **Integumentary (Skin):**
    - a. Lumps Y N
    - b. Rashes Y N
    - c. Skin sores Y N

12. **Musculoskeletal:**
    - a. Gout Y N
    - b. Arthritis Y N
    - c. Chronic back pain Y N
    - d. Cramping in legs Y N
    - e. Joint Pain Y N
    - f. Stiffness Y N

13. **Hematologic**
    - a. Easy bruising Y N
    - b. Bleeding problems Y N
    - c. Anemia Y N

14. **Immune System:**
    - a. Eczema Y N
    - b. Hives Y N
    - c. Itching Y N
    - d. Sneezing Y N

Please note any other health problems you have, not covered by the previous outline list:

_____

_____

_____

_____