UWMC CARDIOLOGY CLINIC INITIAL HEALTH ASSESSMENT

Name:_____ Date:_____	Source of information: (Circle)
Referring MD:_____	Patient Family Chart PMD
Primary Care MD:_____	Interpreter present Outside

Please help us find out about you by filling out the "Patient" side of this form

PATIENT	CLINICIAN
Why are you here to see a cardiologist? _____ _____	CC
Circle any heart problems or symptoms: Heart attack Angina High Blood Pressure Heart Murmur Rheumatic Fever Abnormal Rhythm (arrhythmia) Palpitations, irregular heartbeats Fainting Enlarged heart Chest Pains or Pressure Shortness of Breath Dizziness Swollen legs Heart Failure Blue Lips or Fingernails Leg Cramps when you walk Other_____	HPI
Have you ever had any of the following? Please include date Stress test_____ Echocardiogram_____ Cardiac Catheterization/heart catheterization_____ Coronary Angioplasty (balloon)_____ Coronary bypass surgery_____ Valve surgery_____ Electrophysiology study or procedure_____ Pacemaker or Defibrillator_____ Other_____	
Tell us about your risk for heart disease Please circle YES/NO Smoker YES NO packs per day_____ Years_____ High blood pressure YES NO High cholesterol YES NO Diabetes YES NO Do you exercise (including walking)? YES NO Has a close family member had a heart attack angina or Bypass surgery? YES NO If yes, who?_____ at what age_____ If you are a woman, have you passed menopause (Change of life) YES NO If yes, what age?_____ Do you take estrogen replacement? YES NO Please tell us anything else about your heart: _____	

U:

Name:

DOB:

PATIENT	CLINICIAN

Please list any illness you are currently being treated for or have been treated for in the past:

PMESH

Past Med History

1)_____
2)_____
3)_____
4)_____
5)_____

Have you had any operations? Any injuries?

Past Surg History

1)_____
2)_____
3)_____
4)_____
5)_____

Social History

Marital Status_____
With whom do you live?_____
Occupation_____
Leisure Activities_____
_____
Education Level_____

Health Habits:
How much alcohol do you drink?_____
Do you use any drugs YES NO

Circle if anyone in your immediate family (parents, siblings, children) have any of the following:

Family History

Heart problems
High blood pressure
Diabetes
Cancer
Other_____

Are you allergic to any medications: YES NO

Allergies

List medications to which you are allergic and your reaction

Medications	Reaction
_____	_____
_____	_____
_____	_____

Learning Assessment

Learning

Primary language: __English__Spanish__Russian __Vietnamese__Chinese__Korean__Other_____
Would you like an interpreter at your appointments? YES NO

Do you have any religious or cultural practices that we should consider in your visit with us? YES NO
If yes please explain:_____
_____

How do you prefer to learn?___Seeing (Pictures/ Videotape)___Hearing (audiotape/verbal cues) ___Doing (hands on)

U:

Name:

DOB:

Regional Heart Center Cardiovascular Clinic

Referring Provider _____Clinic/Practice _____

Primary Care & Other Provider(s) _____Clinic/Practice _____

Have you had any interval tests you want to discuss? Yes/No
If yes, what test_____
Have you been hospitalized since your last healthcare visit? Yes/No
If yes, where and when?_____

Area below is for clinician notes

Please circle any symptoms you are having. If you are not having any of the symptoms check the "no symptoms" box.

Lack of energy; trouble sleeping; loss of appetite Weight loss; weight gain; fevers	No Symptoms ☐
Chest pain, shortness of breath with exertion, lying flat or at night, palpitations, fainting, syncope, swelling of the ankles, ICD shock, pacemaker Exercise, I exercise____times/week. I can walk____☐ Blocks ☐ or ≥ 1 mile before I need to stop. I can walk ☐ 0 ☐1 ☐ 2 or more flights of stairs w/out stopping	☐ ☐
Hearing problems; buzzing or ringing in the ears Allergies; hay fever; Sinus problems	☐
Breathing problems; wheezing, cough, coughing blood, asthma, tuberculosis	☐
Stomach problems; indigestion, nausea, vomiting, ulcers, diarrhea, bloody or black stools, jaundice, liver problems, gallstones	☐
Urinary problems; frequency, infections, stones, bladder incontinence, impotence	☐
Joint pains; swelling or redness, arthritis, back pain, muscle aches or tenderness, gout	☐
Skin problems; rash, itching	☐
Women: breast lumps	☐
Paralysis (even temporary); stroke, numbness, loss of balance Seizures, loss of memory, head aches	☐
Unusual thoughts; nervousness, crying, sadness, depression, suicide attempts	☐
Thyroid disorder; diabetes, excess thirst, hunger or urination	☐
Bleeding; easy bruising, anemia, cancer	☐
Pain? Yes/No Location_____Intensity(1-10)_____ Please describe_____ Do you want to talk about your pain today? Yes/No	☐

Habits
☐ I do not smoke ☐ I smoke____packs/day

☐I would like to discuss quitting smoking

☐I drink____alchoholic beverages/day

U:

Name:

DOB:

Physician_____ Date_____

Clinician only (Patients please do not fill out this page.)

General Appearance_____
Weight_____kg or lb Change from last visit_____
Pulse_____BP:_____Sitting (Rt)_____(Lt)_____
Respirations_____ Temp_____ O2Sat_____

PHYSICAL EXAM

Eyes:
PERLA_____Lids_____Arcus_____
Xanth_____Fundi_____

Oral: Oral Mucosa_____
Teeth/Gums/Palate

Neck: Thyroid_____ROM_____
Carotid_____JVD_____

Resp: Effort_____Ausc_____

Heart: Rate/Rhythm_____
PMI_____
S1/S2_____Sounds_____S3/S4_____
Thrills/Rub_____Murmur_____

Abdomen:
Masses/Tenderness_____
Spleen_____Bowel_____
Sounds_____Liver_____

Musuloskeletal:
Back Curvature_____
Gait_____Exercise Tolerance_____
Tone_____Strength_____

Extremities:
Clubbing_____Edema_____
Cyanosis_____

	R	L
Pulses	_____	_____
Brachial	_____	_____
Femoral	_____	_____
Popliteal	_____	_____
Post Tibial	_____	_____
Dorsalis Pedis	_____	_____

Skin:_____

Neuropsych:
Mood_____Oriented_____

IMPRESSION:

PLAN/RECOMMENDATIONS:

I have personally interviewed and examined this patient and agree with the findings documented above

_____Date_____