



*Sutter Regional  
Medical Foundation*

A Sutter Health Affiliate

## **SUTTER REGIONAL MEDICAL FOUNDATION CARDIOLOGY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Have you been hospitalized in the last 5 years? **If so, please notify our staff.**

**Chief Complaint:** What is the primary problem that you are having?

Don't write below this line

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**HPI:**

**PAST MEDICAL HISTORY:**

Operations:

Current Medications:

Name	Dose	How often you take
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Habits:

Tobacco: How many packs per day? \_\_\_\_\_  
How many years have you/did you smoke? \_\_\_\_\_  
When did you quit? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Alcohol: What type? \_\_\_\_\_  
How much per week? \_\_\_\_\_

Allergies:

Menstrual History (women)

Last menstrual period: \_\_\_\_\_  
How many times pregnant: \_\_\_\_\_  
Miscariages: \_\_\_\_\_ Abortions: \_\_\_\_\_ C-Section: \_\_\_\_\_  
Any problems during pregnancy or delivery?

Do you have a history of other medical problems?

Heart attack	Diabetes	Kidney problems
Hypertension (high Blood Pressure)		Gout

**FAMILY HISTORY**

Mother: Age: \_\_\_\_\_ Health Status \_\_\_\_\_ Deceased \_\_\_\_\_

Father: Age: \_\_\_\_\_ Health Status \_\_\_\_\_ Deceased \_\_\_\_\_

Brothers: List ages, health status, and cause of death if applicable

Sisters: List ages, health status, and cause of death if applicable

**SOCIAL HISTORY**

Where were you born?

Where were you raised?

Marital Status?      Married      Single      Divorced      Widow/Widower

With whom do you live?

Employment:

Do you have children?      List ages, sex, health status

**Do you have any other health issues? Circle all that apply**

- |                                       |   |                                |
|---------------------------------------|---|--------------------------------|
| Headaches                             | Eye problems  | Ear or hearing problems        |
| Dentures                              | Thyroid disease   | Chest pain or discomfort       |
| Shortness of breath                   | Edema (swelling of legs)                                | Cough                          |
| Sputum or phlegm                      | Sleep difficulty    Snoring (has anyone said you snore) |                                |
| Breast discomfort or discharge        | Abdominal pain  | Diarrhea                       |
| Constipation                          | Bloody or black stool                                   | Hemorrhoids                    |
| Frequent urination                    | Reduced urinary stream                                  | Difficulty starting to urinate |
| Blood in urine                        | Arthritis or joint pain                                 | Leg cramps                     |
| Pain in legs or buttocks when walking |   | Difficulty walking             |

**Physical Exam: B/P** \_\_\_\_\_ **P** \_\_\_\_\_ **R** \_\_\_\_\_ **Temp** \_\_\_\_\_ **Ht** \_\_\_\_\_ **Wt** \_\_\_\_\_

**HEENT:**

**Neck:** JVP \_\_\_\_\_ Thyroid \_\_\_\_\_ Corotid \_\_\_\_\_ L \_\_\_\_\_ R \_\_\_\_\_

Chest

Breast

Heart

Abdomen

Extremities

Pulses

Genital/Rectal

Neuro

Hemoccult