Jeffery M. Apple, M.D.
Phillip J. Church, M.D.
Stephen J. Dewan, M.D.
Emery W. Dilling, M.D.
Mark C. Felger, M.D.
Kenneth A. Fox, M.D.
Eric M, Hoenicke, M.D.

Andrew T. Hume, M.D.
Jeffrey S. Jobe, M.D.
Faraz Kerendi, M.D.
William F. Kessler, M.D.
Hunter Q. Kirkland, M.D.
Michael C. Mueller, M.D.
R. Brent New, M.D.

John D. Oswalt, M.D.
John K. Politz, M.D.
Scott A. Seidel, M.D.
Stephen M. Settle, M.D.
Mark T. Stewart, M.D.
Joe K. Wells, III, M.D.

Cardiothoracic and Vascular Surgeons
1010 W. 40th St., Austin, TX 78756
Tel: (512) 459-8753 Fax: (512) 459-0586

HISTORY AND PHYSICAL/CONSULTATION FORM

Date _____

Name _____ **Age** _____ **Sex** ____

Referring Physician/Other Treating Physicians _____

_____

PERSONAL INFORMATION

Birthdate _____ Marital Status _____ Employment Status: ____ Employed ____ Retired ___ Disabled

Occupation _____ If disabled, what reason? _____

CHIEF COMPLAINT: (Reason for today's visit)

_____
_____
_____

PAST HOSPITALIZATIONS & SURGERIES (Hospitalizations and surgical procedures.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

CHILDHOOD & ADULT DISEASES: Have you had any of the following diseases diagnosed?

Please list your childhood illnesses: _____

Adult illnesses:

____ asthma	____ pneumonia	____ tuberculosis	____ thyroid disorder	____ kidney failure
____ bronchitis	____ emphysema	____ hepatitis	____ high cholesterol	____ rheumatic fever
____ diabetes	____ cancer	____ heart disease	____ blood disorders	____ blood clots
____ high blood pressure				

Other Illnesses:

_____
_____
_____

*Positive and negative responses reviewed and confirmed. _____ M.D. initials

Patient Name _____

MEDICATIONS

List all prescriptions and dosages, including over-the-counter medication taken including those on an as needed basis.

Name of Medication	Strength	How often do you take it?

ALLERGIES: List any medication, X-ray dye, iodine, contrast media, or food you may be allergic to:

_____

HABITS: Alcohol: No/Yes Amount_____ Street/Recreational drugs: No/Yes IV drug use No/Yes
Testing for HIV or hepatitis _____

How much do you smoke (packs per day)? _____ How many years have you smoked? _____
Have you ever smoked? No/Yes How many packs per day? _____ For how many years? _____

FAMILY HISTORY

Check if any family history of the following diseases:

_____ Angina/heart attacks	_____ Heart failure	_____ High blood pressure	_____ Diabetes
_____ High cholesterol	_____ Rheumatic fever	_____ Strokes	_____ Congenital heart disease
_____ Bleeding disorders	_____ Blood clots	_____ Kidney failure	_____ Aneurysm

Other: _____

_____

*Positive and negative responses reviewed and confirmed. _____ M.D. initials

Patient name _____

REVIEW OF SYSTEMS: Please check if you are experiencing any of these symptoms.

General: _____**No problems**
_____ fever _____ sweats _____ weakness _____ weight change _____ anxiety/depression
_____ chills _____ fatigue _____ insomnia _____ irritability

Skin: _____ **No problems**
_____ color changes _____ skin eruptions _____ itching _____ scaling _____ easy bruising

Eyes: _____ **No problems**
_____ glasses _____ color blindness _____ blind spots _____ redness/swelling _____ excessive tearing
_____ blurring _____ night blindness _____ double vision _____ discharge _____ sensitivity to light

Ears: _____ **No problems**
_____ pain _____ deafness _____ ringing in ears _____ dizziness _____ itching _____ discharge

Nose: _____ **No problems**
_____ excessive bleeding _____ nasal discharge ____ sinusitis ____ blockage

Mouth: _____ **No problems**
___ dentures ___ abnormal taste ___cavities ___ gum disease ___speech difficulty ___hoarseness

Neck: _____ **No problems**
___ swelling ___ pain ___ goiter ____stiff neck ____ masses/nodes

Respiratory: _____ **No problems**
_____ cough _____ sputum production _____ wheezing _____ coughing up blood _____ shortness of breath

Cardiovascular: _____ **No problems**
_____ irregular or fast heart beat _____ chest pain _____ dizziness _____ pain in calves _____ swelling

Gastrointestinal: _____ **No problems**
____ tooth or gum disease _____ belching _____ heartburn _____ abdominal pain _____ mucous in stools
____ difficulty chewing _____ bloating _____ constipation _____jaundice _____ black/tarry stools
____ difficulty swallowing_____vomiting _____ diarrhea _____ bloody stools _____ rectal pain

Genitourinary: _____ **No problems**
____ difficulty urinating _____ painful urination _____ How many times do you have to urinate during the night?
____ incontinence (leaking) ____ kidney stones _____ blood in urine
WOMEN: date of last menstrual period _____

Endocrine: _____ **No problems**
____ thyroid disorder ____ goiter ____ feel hot or cold when others are not affected

Neurological: _____ **No problems**
____ frequent headaches ____ partial/temporary loss of vision ____ numbness/tingling of face ____ seizures
____ severe headaches ____ partial/temporary loss of speech ____ weakness of arms/legs
____ memory change

Musculoskeletal: _____ **No problems**
____ limitation of movement of joints ____ swelling of joints ____ tenderness of bones or joints _____ backache

Other:

_____

_____

*Positive and negative responses reviewed and confirmed. _____ M.D. initials