St Luke's™
Idaho Cardiology Associates

BRIEF HISTORY FORM

Today's Date_____

Print Name_____ Date of Birth_____

Special Problems or Symptoms

1. What symptoms brought you to the cardiologist today?

   _____

   _____

   _____

2. How long have you had this problem? (number) _____ weeks _____ months_____ years.

3. Have you ever seen a cardiologist or other doctor for this problem in the past?_____
   If YES (a) How did the doctor diagnose your problem (tests performed)?

   _____

   (b) How did the doctor treat your problem?_____

   _____

   (c) Did the treatment help you?_____

   (d) Date of your last EKG?_____ Where was it performed?_____

General Screen

1. Have you ever been told of, or treated for, any chronic or serious illness? ____ Yes ____ No
   If yes, what illness(es)?_____

   _____

2. ARE YOU ALLERGIC TO ANY MEDICATIONS, FOODS (SUCH AS SHELLFISH), OR OTHER SUBSTANCES (SUCH AS IODINE OR DYE)? _____ Yes _____ No
   If yes, what?_____

   _____

3. List ALL medications and dosages that you are currently taking:_____

   _____

   _____

   _____

4. Do you smoke? _____ Yes _____ No Do you use alcohol? _____ Yes _____ No

5. Do you use or have you ever used marijuana, heroin, LSD, cocaine, amphetamines, or other such substances? _____ Yes _____ No

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*** (GO TO OTHER SIDE) ***

Please place an (X) next to any of the following problems that you have right now:

___ Frequent headaches
___Trouble with eyes/vision
___Trouble with ears/hearing
___Trouble with nose
___Congested nose/nosebleeds
___Trouble smelling
___Coughing spells
___Coughing a lot of phlegm
___Trouble breathing (shortness of breath)

___Trouble with stomach/digestion
___Vomiting
___Trouble with bowels
___Constipation
___Loose bowels
___Blood in stools
___Trouble with urination
___Difficulty starting urine
___Trouble with genitals
___Trouble with periods

___Trouble with bruises
___Aching muscles/joints
___Numbness in fingers
___Crying spells
___Work/family problems
___Sexual difficulties
___Fever
___Weight changes
___Fatigue
___Dizzy spells

Give the following information for the last three times you have been hospitalized or seriously ill starting with the most recent. (Do not list normal pregnancies)

	(1)	(2)	(3)
Type of Operation or Serious Illness			
Name of Hospital or Physician			
Address including City and State			
Month and Year Treated			

Please list the following information about your blood relatives:

If deceased, age of death and cause

	Year of Birth	*Major Illnesses*	*Age*	*Cause*
Father				
Mother				
Brother(s)				
and/or				
Sister(s)				

Signature

Date