Dr. James D. Pickett

Cardiovascular Risk Assessment and Patient History Form

Thank you for taking the time to fill out our health questionnaire. This is a confidential record of your medical history and will be kept in this office.

Today's Date Name Date of Birth

Primary Care Provider

Problem today (describe any recent testing)

Current Medications (if none, please write None)

Allergies (Drug, Food, Environmental) Please circle YES or NO. If YES, please list

Past Medical History: Write "Y" for Yes, "N" for No, or "?" if uncertain:

___High Blood Pressure	___Diabetes	___High Cholesterol	___Heart Attack
___Heart Catheterization	___Angioplasty	___Congestive Heart Failure	___Stroke/TIA
___Valve Problem/Heart Murmur	___Rheumatic Fever	___Loss of Consciousness	___Asthma
___Arrhythmia (irregular heartbeat)	___Emphysema	___Pneumonia	___Anemia
___Vascular (blood vessel) Disease	____Ulcer	___Bleeding tendency	___Cancer
___Liver Disease/Hepatitis	___Kidney Disease	___Arthritis	___Glaucoma
___Migraine Headaches	___Thyroid Disease	___HIV Disease	___Autoimmune Disease

___Other _____

Past Surgical History and Hospitalizations: (please list and give approximate dates) ***IF NONE, CHECK HERE*** ☐

1. _____ 2._____

3._____ 4._____

Family Medical History IF NO POSITIVE FAMILY HISTORY, CHECK HERE ☐

Has any blood relative had any of the following? **Write "Y" for Yes, "N" for No, or "?" if uncertain**:

Please indicate the relationship. For example: Father, Mother, Sibling, or other blood relative.

High Blood Pressure	Sudden Death
Diabetes	Congestive Heart Failure
High Cholesterol	Arrhythmia (irregular heartbeat)
Heart Attack	Vascular (blood vessel) Disease
Angioplasty	Cancer

Coronary Bypass Surgery Stroke Other

Social History: circle Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Occupation: Children Place of Birth

Habits:

Smoking (type and amount/day) If former smoker, date you quit

Alcohol (type and amount/day) Caffeine (type and amount/day)

Street Drugs (type and amount/day

Review of Systems (please check "yes" or "no" to ALL)

Yes	No		Yes	No		Yes	No	
☐	☐	**weight loss/gain**	☐	☐	**shortness of breath**	☐	☐	**headache**
☐	☐	**weakness/fatigue**	☐	☐	**cough**	☐	☐	**numbness/weakness**
☐	☐	**fever/night sweats**	☐	☐	**coughing up blood**	☐	☐	**off balance/dizziness**
☐	☐	**blurred/double vision**	☐	☐	**awake from sleep with shortness of breath**	☐	☐	**seizure**
☐	☐	**chest pain/discomfort**	☐	☐	**nausea/vomiting/diarrhea**	☐	☐	**anxious**
☐	☐	**irregular heartbeats**	☐	☐	**heartburn/reflux**	☐	☐	**depressed**
☐	☐	**leg swelling**	☐	☐	**abdominal pain**	☐	☐	**bleeding tendency**
☐	☐	**palpitations**	☐	☐	**rectal bleeding**	☐	☐	**easy bruising**
☐	☐	**discomfort in the thighs/buttocks with activity or exercise**	☐	☐	**muscle weakness/pain**	☐	☐	**frequent infections**
			☐	☐	**joint pain/swelling**			
☐	☐	**purple fingers or toes**	☐	☐	**skin rash**			

Additional Information:

How would you describe your current state of health?

How would you describe your diet?

How often do you exercise?

Do you use alternative/complementary medicine?

Do you have an advance directive or living will?

Is there anything else we should know about you?

Patient Signature Physician Signature

Physician Use Only-Reviewed and updated at subsequent visits:

Practitioner	Date	Practitioner	Date	Practitioner	Date