Bryan HEART

Butler County Health Care Center
402-367-1200 • www.bchccnet.org
372 South 9th Street • David City, NE 68632

Date:_____
Room Number:_____

Out Reach Patient History Worksheet

DESCRIBE YOUR REASON FOR COMING TO SEE US:

_____

_____

Name: _____

CARDIOVASCULAR HISTORY (Please Circle)

1. Heart attack? When:_____ Y N
2. Heart Catheterization? When:_____ Y N
3. Heart surgery or balloon/stent procedure? Y N
   Date:_____ Type:_____
4. Echocardiogram? (Ultrasound of the heart) Y N
5. Do you have any of the following conditions?
   a) Diabetes Y N
   b) High blood pressure Y N
   c) High Cholesterol Y N
   d) Blood clots in the legs/lungs Y N
   e) Heart murmur Y N
   f) Black out spells Y N
   g) Varicose veins, leg discoloration or ulcers Y N

CARDIAC/VASCULAR RISK FACTORS (Please list relationship)

1. Do any family members have a history of:
   a) Heart Disease Y N _____
   b) Diabetes Y N _____
   c) Cancer Y N _____
   d) Stroke Y N _____
   e) Abdominal aortic aneurysm Y N _____
   f) Peripheral arterial disease Y N _____
   g) Carotid disease Y N _____
   h) Aortic dissection Y N _____
   i) High blood pressure Y N _____

HABITS/SOCIAL HISTORY

1. Have you ever smoked/chewed tobacco? Y N
   Packs/day_____ years smoked_____ year quit_____
2. Do you follow a special diet? Y N
3. Do you use caffeine? Y N
   Amount/day_____
4. Do you use alcohol? Y N
   Amount/day_____
5. Have you a history of drug use/addiction Y N
6. Occupation _____ Marital Status _____

PREVIOUS OPERATIONS/SURGERIES **DATE**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

REVIEW OF SYMPTOMS (Please Circle)

1. CARDIOVASCULAR
   a) Chest Pains Y N
   b) Racing Heart Y N
   c) Lower extremity edema Y N
   d) Palpitations Y N
   e) Lightheadedness Y N

2. RESPIRATORY
   a) Shortness of Breath Y N
   b) Cough Y N
   c) Wheezing Y N

3. GASTROINTESTINAL
   a) Abdominal Pain Y N
   b) Nausea Y N
   c) Vomiting Y N
   d) Diarrhea Y N
   e) Black Colored Stools Y N
   f) Bright Red Blood per Rectum Y N

4. SLEEP
   a) Snoring Y N
   b) Excessive Daytime Sleepiness Y N
   c) Do you use CPAP? Y N

5. NEUROLOGIC
   a) Confusion Y N
   b) Numbness/Generalized Y N
   c) Tingling Y N
   d) Dizziness Y N
   e) Fainting Y N
   f) Weakness Y N

6. GENERAL
   a) Fevers Y N
   b) Chills Y N
   c) Fatigue Y N

7. GENITOURINARY
   a) Pain with Urination (Dysuria) Y N
   b) Blood in the Urine (Hematuria) Y N

8. MUSCULOSKELETAL
   a) Muscle Aches, Generalized Y N
   b) Diffuse Joint Pain Y N

9. PSYCHIATRIC
   a) Anxiety Y N
   b) Depression? Y N

10. ENDOCRINE
   a) Night Sweats Y N
   b) Generalized Weakness Y N

11. HEMATOLOGY/LYMPHATIC
   a) Easy Bleeding Y N
   b) Easy Bruising Y N

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Date:		Medical Record #:		Site/Room #:
BH Physician:			Referring Physician/PCP:	
Patient Name:		Age:	Sex:	Marital Status:
Mailing Address:			City:	State: Zip:
Home Phone	Work Phone: Ext. Cell:		Birthdate:	SS#:
Pharmacy:				

REASON FOR VISIT: _____

_____

HISTORY:

VITALS:

Height_____in Weight_____lb 02 Sat_____%

B.P. Right, _____/_____ Left, _____/_____

Pulse_____ Respirations _____ Temp_____

ALLERGIES: _____

_____

MEDICATIONS: _____

_____

_____

_____

_____

_____

_____

Smoking Status: current smoker/chew tobacco

Packs/day_____ years smoked_____ year quit_____

Last Echo: _____

Last NUC: _____

Last Cath: _____ **EF** _____**%**

_____

PLAN: