Imperial Cardiac Center
Imperial Valley Family Care Medical Group

Personal Information

Your Name:		Today's Date:
Birthdate:	Birthplace:	Your Doctor:
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Long Term Relationship		
Your Occupation:		For How Long?

Prior Medical History

Illness		Prior Medical History		Injuries	
Anemia	☐	Cancer	☐	Head Injury	☐
Heart Disease	☐	Peptic Ulcers	☐	Broken Bones	☐
High Blood Pressure	☐	Sexually Transmitted Disease	☐	Back Injury	☐
Diabetes	☐	Pneumonia	☐	**Surgeries**	
Tuberculosis	☐	Hepatitis	☐	Hernia	☐
Stroke	☐	Kidney Disease	☐	Gallbladder	☐
Stomach Ulcers	☐	Asthma	☐	Hysterectomy	☐
Measles	☐	Back Trouble	☐	Appendectomy	☐
Mumps	☐	Blood Transfusion	☐	Prostate	☐
Arthritis	☐			Other:	
Migraine Headaches	☐				

Medicines and Drugs

Medicines Currently Taking	Medicines and Drugs		Personal Habits		
	Allergies		Smoking	☐ Yes	☐ No
	Penicillin	☐	Alcohol	☐ Yes	☐ No
	Sulfa	☐	Other Drug Use	☐ Yes	☐ No
	Other (please list)		Use Seat Belts	☐ Yes	☐ No

Over the counter medicines:

Family History

Father: Alive - Health:

Dead - Cause:

Mother: Alive - Health

Dead - Cause

Brothers / Sisters:

Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Bowel Cancer	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No			

JLJ: 04-94 DATA\FORMS\HLTH_HX.DOC

Patient History Questionnaire
(Please Also Complete Reverse Side)

SYSTEM REVIEW

CIRCLE YES OR NO IF YOU HAVE RECENTLY NOTICED:

GENERAL		
SIGNIFICANT WEIGHT CHANGE	YES	NO
ABNORMAL BRUISING OR BLEEDING	YES	NO
FEVERS	YES	NO
HEAD AND NERVOUS		
DEPRESSED MOOD	YES	NO
SLEEPING PROBLEMS	YES	NO
MEMORY DIFFICULTIES	YES	NO
HEADACHES	YES	NO
DIZZINESS OR FAINTING	YES	NO
EYE DISEASE OR INJURY	YES	NO
TROUBLE SEEING	YES	NO
WEAR CONTACT LENSES OR GLASSES	YES	NO
EAR OR HEARING PROBLEMS	YES	NO
RINGING IN EARS	YES	NO
NOSE BLEEDS	YES	NO
SORE GUMS	YES	NO
BREASTS		
LUMPS	YES	NO
DISCHARGE	YES	NO
CARDIO-RESPIRATORY		
SHORTNESS OF BREATH	YES	NO
SHORT OF BREATH LYING DOWN	YES	NO
ASTHMA OR WHEEZING	YES	NO
SIGNIFICANT COUGHING	YES	NO
COUGHING OR SPITTING UP BLOOD	YES	NO
CHEST PAINS	YES	NO
HEART PALPITATIONS	YES	NO

GASTROINTESTINAL		
CHANGE IN APPETITE	YES	NO
DIFFICULTY SWALLOWING	YES	NO
HEARTBURN	YES	NO
EXCESS GAS	YES	NO
NAUSEA	YES	NO
VOMITING	YES	NO
VOMITING BLOOD	YES	NO
DIARRHEA	YES	NO
CONSTIPATION	YES	NO
HEMORRHOIDS	YES	NO
BLEEDING OR BLACK STOOLS	YES	NO
URINARY		
URINE FREQUENCY	YES	NO
FREQUENT NIGHT URINATION	YES	NO
PAINFUL URINATION	YES	NO
BLOOD IN URINE	YES	NO
LOSS OF URINE CONTROL	YES	NO
SEXUALLY ACTIVE	YES	NO
SAFE SEX ACTIVITY	YES	NO
SKIN AND JOINTS		
UNUSUAL PAIN IN JOINTS	YES	NO
SWELLING OR STIFFNESS	YES	NO
PAIN OR WEAKNESS IN MUSCLES	YES	NO
SKIN SORES OR RASH	YES	NO
LEG PAIN WHEN WALKING	YES	NO
MUSCLE CRAMPS	YES	NO

GYNECOLOGICAL

AGE WHEN PERIODS STARTED ____________

FIRST DAY OF LAST PERIOD ____________

USUAL LENGTH OF PERIODS ____________

USUAL PAIN WITH PERIODS YES NO

NUMBER OF PREGNANCIES ____________

NUMBER OF MISCARRIAGES / ABORTIONS ____________

NUMBER OF CHILDREN ____________

SIGNATURE / INITIALS OF MD REVIEWING: