NEWPORT CARDIAC & THORACIC SURGERY

ANTHONY D. CAFFARELLI, M.D.
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TELEPHONE: 949-650-3350
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PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name____ Today's Date ___________________
Date of Birth ______________________________ Age _____________ MR# ___________________________________
Cardiologist ________________________________ Primary Care Physician _____________________________________
Pulmonologist ______________________________ Other Physician ____

MAIN REASON FOR YOUR VISIT TODAY

____
____

HPI (TO BE FILLED OUT BY MD, PA, NP)

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

MEDICAL HISTORY

Check all that apply

Height ______ Weight______

- ○ Anemia
- ○ Asthma
- ○ Arthritis
- ○ Bleeding/Blood disorder
- ○ Breast Cancer
- ○ Cancer(s)__________
- ○ Cataracts
- ○ Colitis
- ○ Depression/Anxiety
- ○ Diabetes
- ○ Emotional/Mental Illness
- ○ Emphysema/COPD
- ○ Epilepsy/Seizures
- ○ Glaucoma
- ○ Hay Fever
- ○ Heart Attack
- ○ Heart Problems
- ○ Irregular Heart Rhythms
- ○ Atrial Fibrillation
- ○ GI Bleeding
- ○ Hepatitis/Jaundice
- ○ High Blood Pressure
- ○ HIV/AIDS
- ○ Kidney Disease
- ○ Kidney Stones
- ○ Liver Disease
- ○ Osteoporosis
- ○ Rheumatic Fever
- ○ Stroke/TIA
- ○ Thyroid Disease
- ○ Tuberculosis
- ○ Ulcers
- ○ High Cholesterol
- ○ Childhood Illnesses

____
____
____
____

Other Medical Issues

____
____
____
____
____
____
____
____

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SURGICAL HISTORY

List surgeries and specify year. Attach additional sheets as necessary.

____

____

____

____

____

____

____

ILLNESSES / INJURIES / HOSPITALIZATIONS

List all illnesses / injuries requiring hospitalization.

____

____

____

____

MEDICATIONS

Please fill out the attached medication list.

ALLERGIES

List medications and reaction if known.

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____

Food: ____

Other: ____

TAPE IODINE LATEX

SOCIAL HISTORY

Marital Status: Single Married Divorced Separated

Living Arrangement: Alone Roommate Spouse Children Parents/Sibling

What is/was your occupation? ____

When did you quit smoking? ____

How many packs per day? ______________________ For how long? ______________________

How much alcohol do you drink? ____

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FAMILY HISTORY

	Age	Medical Problems	If deceased, Age and Cause of Death
Father	__________	____________________________	____
Mother	__________	____________________________	____
Sibling ♀ ♂	________	____________________________	____
Sibling ♀ ♂	________	____________________________	____
Sibling ♀ ♂	________	____________________________	____
Sibling ♀ ♂	________	____________________________	____
Children ♀ ♂	_____	____________________________	____
Children ♀ ♂	_____	____________________________	____
Children ♀ ♂	_____	____________________________	____
Children ♀ ♂	_____	____________________________	____

REVIEW OF SYSTEMS

Please answer yes or no to the following symptoms. Elaborate as necessary.

CONSTITUTIONAL SYMPTOMS

			Comments
Good general health lately	Yes	No	____
Recent weight change	Yes	No	____
Fever	Yes	No	____
Fatigue	Yes	No	____
Headaches	Yes	No	____
History of genetic syndromes (Personal or Familial)	Yes	No	____

EYES

			Comments
Eye disease or injury	Yes	No	____
Wear glasses/contacts	Yes	No	____
Blurred or double vision	Yes	No	____
Glaucoma	Yes	No	____
Cataracts	Yes	No	____
Lens Dislocation	Yes	No	____

EARS/NOSE/THROAT/MOUTH

			Comments
Hearing loss or ringing	Yes	No	____
Earaches or drainage	Yes	No	____
Chronic sinus problem	Yes	No	____
Nose bleeds	Yes	No	____
Sore throat or voice change	Yes	No	____
Swollen glands in neck	Yes	No	____
Last seen by Dentist (name & phone#)	Date:		____

CARDIOVASCULAR

			Comments
Heart trouble	Yes	No	____
Chest pain or angina	Yes	No	____
Palpitations	Yes	No	____
Shortness of breath w/walking	Yes	No	____
Swelling of feet/ankles/hands	Yes	No	____
Heart murmur	Yes	No	____

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Bicuspid AV	Yes	No	______________________________
Vein Stripping	Yes	No	______________________________
Conduit	Yes	No	______________________________

RESPIRATORY			**Comments**
Chronic or frequent coughs	Yes	No	______________________________
Spitting up blood	Yes	No	______________________________
Shortness of breath	Yes	No	______________________________
Asthma or wheezing	Yes	No	______________________________

GASTROINTESTINAL			**Comments**
Difficulty Swallowing	Yes	No	______________________________
Loss of appetite	Yes	No	______________________________
Change in bowel movements	Yes	No	______________________________
Nausea or vomiting	Yes	No	______________________________
Frequent diarrhea	Yes	No	______________________________
Painful bowel movements	Yes	No	______________________________
Constipation	Yes	No	______________________________
Rectal bleeding/blood in stool	Yes	No	______________________________
Abdominal pain or heartburn	Yes	No	______________________________
Peptic Ulcer	Yes	No	______________________________
Colonoscopy	Yes	No	______________________________

GENITOURINARY			**Comments**
Frequent urination	Yes	No	______________________________
Burning or painful urination	Yes	No	______________________________
Blood in urine	Yes	No	______________________________
Change in force of urination	Yes	No	______________________________
Incontinence or dribbling	Yes	No	______________________________
Kidney Stones	Yes	No	______________________________
PSA	Yes	No	______________________________

MUSCULOSKELETAL			**Comments**
Joint pain	Yes	No	______________________________
Joint stiffness or swelling	Yes	No	______________________________
Weakness of muscles or joints	Yes	No	______________________________
Muscle pain or cramps	Yes	No	______________________________
Back pain	Yes	No	______________________________
Cold extremities	Yes	No	______________________________
Difficulty in walking	Yes	No	______________________________
Scoliosis	Yes	No	______________________________
Flat feet	Yes	No	______________________________

SKIN/INTEGUMENTARY			**Comments**
Rash or itching	Yes	No	______________________________
Skin lesions	Yes	No	______________________________
Varicose veins	Yes	No	______________________________
Breast lump	Yes	No	______________________________
Stretch marks	Yes	No	______________________________

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NEUROLOGICAL			**Comments**
Frequent/recurring headache	Yes	No	______
Light headed or dizzy	Yes	No	______
Convulsions or seizures	Yes	No	______
Numbness/tingling sensations	Yes	No	______
Tremors	Yes	No	______
Paralysis	Yes	No	______
Stroke	Yes	No	______
Head injury	Yes	No	______

ENDOCRINE			**Comments**
Glandular or hormone problem	Yes	No	______
Hyperthyroidism	Yes	No	______
Hypothyroidism	Yes	No	______
Diabetes	Yes	No	______

HEMATOLOGICAL/LYMPHATIC			**Comments**
Slow to heal after cuts	Yes	No	______
Bleeding or bruising tendency	Yes	No	______
Anemia	Yes	No	______
Phlebitis	Yes	No	______
Past Transfusion	Yes	No	______
Enlarged glands	Yes	No	______

ADDITIONAL COMMENTS ______________________________

____

PHYSICIAN SIGNATURE: ______________________ **DATE:** ______________

 Patient Name______________________ MR #______________Date__________