**History & Physical Form PALMETTO CARDIOLOGY OF YORK CO. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Harry E Hicklin, M.D. Chart # \_\_\_\_\_\_\_\_\_\_\_**

**Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_**

**Referring Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ & Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your Preferred Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ & Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_& Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Today’s Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardiac Risk Factors:**

**High Blood pressure? \_\_\_\_\_yes \_\_\_\_\_no High Cholesterol \_\_\_\_\_\_yes \_\_\_\_\_\_no**

**Diabetes? \_\_\_\_\_yes \_\_\_\_\_no Tobacco Use? \_\_\_\_\_\_\_yes \_\_\_\_\_\_\_no**

**Family History of early Coronary Artery Disease (define as first degree relative with coronary artery disease before age 60)**

**Does anyone in your family (parents, siblings) have heart disease? \_\_\_\_\_\_\_yes \_\_\_\_\_no**

**Has anyone in your family (parents, siblings) had sudden death? \_\_\_\_\_\_\_yes \_\_\_\_ \_no**

**Has anyone in your family (parents, siblings) had a stroke? \_\_\_\_\_\_\_yes \_\_\_\_\_ no**

**Past Surgical History**

**Date: Type of Surgery? What Hospital?**

**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1**

**List All hospitalizations you have had within the past five years (other than previous page)**

**Date: Facility Reason**

**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any other major illnesses or diagnoses? If yes, list below:**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

**Single\_\_\_\_\_\_\_\_ Married\_\_\_\_\_\_\_\_ Widowed\_\_\_\_\_\_\_\_\_ Divorced\_\_\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_\_\_**

**OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Education Level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do You Drink Alcohol: \_\_\_\_\_yes \_\_\_\_No How Often? \_\_\_\_\_daily \_\_\_\_weekly \_\_\_\_\_\_\_Rarely**

**Caffeine use: \_\_\_\_\_Daily \_\_\_\_\_Sometimes \_\_\_\_\_\_\_Never**

**Do you have any medication allergies? \_\_\_\_yes \_\_\_\_no.**

**Please list: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had a reaction to shellfish? \_\_\_\_\_yes \_\_\_\_no**

**Have you ever had a reaction to X-ray dye? \_\_\_\_\_yes \_\_\_\_no**

**REVIEW OF SYSTEMS: Check if you have had any of the following:**

**General: \_\_\_\_\_Recent illness**

 **\_\_\_\_\_ Weight loss or gain greater than 10 lbs in last 6 months**

**2**

**Head/Ears/Nose/Throat \_\_\_\_\_\_Headaches**

 **\_\_\_\_\_\_Cataracts or glaucoma**

 **\_\_\_\_\_\_Decreased hearing**

 **\_\_\_\_\_\_Frequent nose bleeding**

 **\_\_\_\_\_\_Trouble swallowing foods or liquids**

**Heart: \_\_\_\_\_Chest pain**

 **\_\_\_\_\_Congestive Heart Failure**

 **\_\_\_\_\_ Shortness of breath with exertion**

 **\_\_\_\_\_ Trouble lying flat to sleep because short of breath**

 **\_\_\_\_\_ Passing Out**

**Lungs: \_\_\_\_\_ Asthma**

 **\_\_\_\_\_ COPD (bronchitis or emphysema**

**GI: \_\_\_\_\_ History of bleeding**

 **\_\_\_\_\_ Reflux**

**GU: \_\_\_\_\_ Hx of kidney dysfunction**

 **\_\_\_\_\_ Frequent or painful urination**

**Neurological: \_\_\_\_\_ Hx of mini-stroke/stroke**

 **\_\_\_\_\_ Vertigo/dizziness**

**3**

**Psychiatric: \_\_\_\_\_ History of anxiety or depression**

**Vascular: \_\_\_\_\_\_ History of blood clots in legs**

 **\_\_\_\_\_\_ Leg swelling**

 **\_\_\_\_\_\_ Hands/feet turn blue in cold**

 **\_\_\_\_\_\_Legs/buttock pain with walking (if yes, then answer questions) Does pain begin when standing still or sitting? \_\_\_yes \_\_\_ No**

 **Does pain begin when walking uphill or in a hurry? \_\_\_yes \_\_\_No**

 **Does pain begin when walking at ordinary pace? \_\_\_yes \_\_\_No**

 **Does pain go away with resting less than 10 min? \_\_\_yes \_\_\_No**

**Hematologic: \_\_\_\_\_\_History of bleeding disorder or easy bruising**

**Endocrine: \_\_\_\_\_\_History of thyroid disease**

**To Be Completed by Staff:**

**Physical Exam:**

**Height: \_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_ BMI \_\_\_\_\_\_**

**Vitals: HR\_\_\_\_\_\_\_\_\_\_\_\_ B/P Lt arm\_\_\_\_\_\_\_\_\_\_ Rt arm\_\_\_\_\_\_\_\_\_\_**

**Orthostatics: (if appropriate) \_\_\_\_\_\_Lying BP \_\_\_\_\_\_Sitting BP \_\_\_\_\_\_\_Standing BP**

 **\_\_\_\_\_\_HR \_\_\_\_\_\_\_\_\_HR \_\_\_\_\_\_\_\_\_HR**

**4**

**Physician Physical Findings:**

**1.**

**2.**

**3.**

**4.**

**Treatment Plan**

**1.**

**2.**

**3.**

**4.**

**Harry E Hicklin, MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **5**