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?
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

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

Physician Physical Findings:

1.

2.

3.

4.

Treatment Plan

1.

2.

3.

4.

Harry E Hicklin, MD _____
Date:_____