Revere Health
Let's live better.

Name:	Date:
Chief Complaint:	

Cardiovascular History			**Cardiac Risk Factors:**		
Do you have chest discomfort?	Yes	No	Do you have High Blood Pressure?	Yes	No
If yes what does it feel like?			Do you have Diabetes Mellitus?	Yes	No
Where is it located?			Have you ever smoked cigarettes?	Yes	No
Do you have difficulty breathing when you walk or go up stairs?	Yes	No	Do you drink alcohol?	Yes	No
When you lie down, do you need to use pillows to breath comfortably?	Yes	No	Have you had high cholesterol?	Yes	No
Do you have swelling in your legs?	Yes	No	Have you or any member of your family had a heart attach, bypass surgery, balloons, or stents?	Yes	No
How many times per night do you get up to urinate?					
Have you had palpitations, dizziness, or passing out episodes?	Yes	No			
Have you had scarlet fever, strep throat, or rheumatic fever? Please circle which one.					
Have you had a heart murmur?	Yes	No			

Allergies:

Medications: (include dosages)

Previous Surgeries: What operations have you had? What year?

CNS			**Pulmonary:**		
Have you had a stroke?	Yes	No	Have you had asthma?	Yes	No
Have you had seizures?	Yes	No	Have you had pneumonia?	Yes	No
Have you had episodes when you cannot move part of your body?	Yes	No	Have you had bronchitis?	Yes	No
Do you have episodes in which you cannot see part of all of your visual field?	Yes	No	Have you coughed up blood?	Yes	No
Do you have episodes in which you have trouble speaking?	Yes	No			
Urinary:			**GI Tract:**		
Have you had urinary tract infections?	Yes	No	Do you have difficulty swallowing?	Yes	No
Have you had kidney stones?	Yes	No	Does it hurt when you swallow?	Yes	No
Have you had blood in your urine?	Yes	No	Have you had indigestion, heartburn, or ulcers?	Yes	No
Have you had a slow-down in your kidney function?	Yes	No	Have you thrown-up blood or material that looks like coffee grounds?	Yes	No
Have you had kidney inflammation?	Yes	No	Do you have blood in bowel movements?	Yes	No
Endocrine:			**Skin:**		
Have you had high or low thyroid?	Yes	No	Have you had any skin rashes:	Yes	No
Do you have hot or cold intolerance?	Yes	No			
Musculoskeletal:			**Additional Comments:**		
Have you had arthritis?	Yes	No			
Do your legs hurt or become tired when you walk?	Yes	No			
If yes, how far can you walk before you have to stop to rest?					
Have you had ulcers or sores on your legs or feet?	Yes	No			
Do your legs swell?	Yes	No			
Have you had blood clots in your legs?	Yes	No			
Have you had blood clots go to your lungs?	Yes	No			