1PA

Kansas Heart HOSPITAL

BRIEF OUTPATIENT HEALTH HISTORY

PLEASE CIRCLE CORRECT RESPONSE BELOW:

Glasses / Contacts Dentures: Uppers / Lowers Partial: Uppers / Lowers Hearing Aid: Left / Right Loose Teeth # _____

Current Medications	Dosage	Frequency	Last Dose	Current Medications	Dosage	Frequency	Last Dose
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

PATIENT HEALTH HISTORY – *check all that apply*

History of

- ❒ Asthma _____
- ❒ Bronchitis or Chronic Cough _____
- ❒ Emphysema _____
- ❒ Shortness of Breath _____
- ❒ Pneumonia _____
- ❒ Tuberculosis When: _____
- ❒ Never Smoked _____
- ❒ Currently Smokes # of packs per day _____
- ❒ Ex-smoker Month & Year quit: _____
- ❒ Live with a smoker _____
- ❒ Caffeine use _____
- ❒ Alcohol use _____
- ❒ History of MRSA _____
- ❒ Peripheral Vascular Disease _____
- ❒ Blood Clot in legs When:_____
- ❒ Heart Attack When:_____
- ❒ Last BM _____

History of

- ❒ Stroke /T IAs When:_____
- ❒ Pacemaker When:_____
- ❒ Heart Murmur _____
- ❒ Chest Pain / Angina _____
- ❒ Congestive Heart Failure _____
  - ❒ Ankles swelling _____
  - ❒ Fluid in lungs _____
- ❒ Palpitations irregular / fast heartbeat _____
- ❒ Rheumatic fever _____
- ❒ High/Low Blood Pressure _____
- ❒ Previous Heart Cath _____
- ❒ Angioplasty / stent When: _____
- ❒ History of sleep apnea _____
- ❒ CPAP Settings: _____
- ❒ Oxygen at night _____
- ❒ Last menstrual period _____

History of

- ❒ Seizures / Epilepsy _____
- ❒ Anemia _____
- ❒ Blood Transfusion _____
- ❒ Stomach Disease/Ulcer _____
- ❒ Hiatal Hernia _____
- ❒ Hepatitis / liver disease _____
- ❒ HIV _____
- ❒ Arthritis _____
- ❒ Disabilities What:_____
- ❒ Kidney Disease _____
- ❒ Thyroid _____
- ❒ Diabetes / Last Accu✓ Result _____
- ❒ Hypoglycemia Date _____ Time _____
- ❒ Dizziness/Motion Sick _____
- ❒ Prostate/bladder problems _____
- ❒ Cancer What_____ When _____
- ❒ Pneumococcal vaccine When _____
- ❒ Influenza vaccine When _____

SURGICAL HISTORY – *check all that apply*

- ❒ Heart Surgery
  - ❒ Bypass When:_____
  - ❒ Valve When:_____
- ❒ Blood Vessels – neck (carotid) When:_____
- ❒ Blood Vessels – legs When:_____
- ❒ Anesthesia Reaction: What happened:_____
- ❒ Tonsillectomy When:_____
- ❒ Gallbladder When:_____
- ❒ Hysterectomy When:_____
- ❒ Appendectomy When:_____

OTHER – please list: When:_____

When:_____

ALLERGIES – *please list*

Allergy to iodine, shellfish, seafood ❒ Yes ❒ No

Allergies:	**Reactions:**	**Allergies:**	**Reactions:**
Allergies:	**Reactions:**	**Allergies:**	**Reactions:**
Allergies:	**Reactions:**	**Allergies:**	**Reactions:**

PATIENT NAME: _____ **DATE:** _____

EMERGENCY CONTACT NAME: _____ **PHONE NUMBER:** _____

HOSPITAL USE ONLY

Last ate at:_____

Date:_____ Time:_____ Ht:_____ Wt:_____

T:_____ P:_____ R:_____ BP:_____ SAO2:_____%

Signature/Title:_____ Initials:_____

Patient Label