USF Health Cardiothoracic Surgery & Transplantation

Robert Hooker, MD, Erol Belli, MD, John Dunning, MD, Riad Meada MD

Name:_____ Phone:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Social Security #: _____- _____- _____ Date of Birth: ____/_____/_____ Age: _____
Marital Status: _____ Employment: _____
E-mail Address: _____
Emergency Contact:_____ Phone: _____
Insurance Name:_____ Policy #:_____ Group #: _____
Name of Subscriber:_____ Date of Birth: ____/_____/_____
Relationship to Subscriber: _____

Primary Care Physician:

Name:_____

Address:_____

Phone:_____

Fax:_____

Cardiologist/Pulmonologist:

Name:_____

Address:_____

Phone:_____

Fax:_____

Where you referred by your PCP or Cardiologist/Pulmonologist? If no, Please provide:

_____

Reason for your visit: _____

Review of Systems (continue):

What Medications do you take? Please bring a list of Medications to your appointment.

Name of Medicine	**Dose(mg)**	**How many times per day?**

Allergies:

_____

Past Medical History:

[ ] High Blood Pressure
[ ] Coronary Artery Disease
[ ] Asthma
[ ] COPD
[ ] Liver Disease
[ ] Seizures
[ ] Stroke
[ ] Heart Murmur
[ ] Emphysema
[ ] Heart Attack
[ ] Kidney disease
[ ] Diabetes
[ ] Cancer
[ ] Thyroid Disease
[ ] Valvular Heart Disease
[ ] High Cholesterol
[ ] Ulcer
[ ] Gastric Reflux
[ ] Anemia
[ ] Hernia
[ ] Heart Rhythm Disorder

Other: _____

Past Surgical History:

1. _____ Mon/Yr.: _____
2. _____ Mon/Yr.: _____
3. _____ Mon/Yr.: _____
4. _____ Mon/Yr.: _____
5. _____ Mon/Yr.: _____
6. _____ Mon/Yr.: _____
7. _____ Mon/Yr.: _____
8. _____ Mon/Yr.: _____

Cardiac Procedures:

	Date	**Hospital/ Clinic**
Echocardiogram:		
Chest CT Scan/MRI:		
Heart Catheterization:		
Other:		

Smoking History: [ ] Never smoked [ ] previous smoker- Quit smoking ____/_____
[ ] Smoke now- How often? _____

Alcohol History: [ ] Never Drink [ ] Previous Drinker – Quit drinking_____/_____
[ ] Drink now- How often? _____

Other Drugs: _____

Social History:

Who lives with you now? _____

Who would be available to help you in the event of a major operation?

Work History:

Occupation:_____ How many years?_____

Family History:

	Relationship	Cause of Death?
High Blood Pressure [ ]		
Heart Murmur [ ]		
Coronary Artery Disease [ ]		
Emphysema [ ]		
Asthma [ ]		
Heart Attack [ ]		
Kidney Disease [ ]		
Liver Disease [ ]		
Diabetes [ ]		
Diabetes [ ]		
Seizures [ ]		
Cancer [ ]		
Stroke [ ]		
Thyroid Disease [ ]		
Other:		

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Review of Systems

General:	[ ] Weight gain [ ] Weight loss [ ] Weakness [ ] Fatigue [ ] Fever [ ] None [ ] Other _____
Eyes:	[ ] Redness [ ] Tearing [ ] Dryness [ ] Double Vision [ ] Cataracts [ ] Glasses [ ] Glaucoma [ ] Pain [ ] None [ ] Other _____
Ears:	[ ] Itching [ ] Vertigo [ ] Infections [ ] Decreased Hearing [ ] Ringing [ ] Discharge [ ] Earaches [ ] None [ ] Other_____
Nose:	[ ] Recent Cold [ ] Stuffiness [ ] Bleeding [ ] Discharge [ ] Sinus Infection [ ] None [ ] Other _____
Mouth:	[ ] Gum Bleed [ ] Sore Throats [ ] Hoarseness [ ] None [ ] Other _____
Cardiac:	[ ] Chest Pain [ ] Murmur [ ] Irregular Heartbeats [ ] Fainting [ ] Palpitations [ ] None [ ] Other _____
Pulmonary:	[ ] Cough [ ] Sputum [ ] Wheezing [ ] Asthma [ ] Shortness of Breath [ ] None [ ] Other _____

GI:	[ ] Constipation [ ] Nausea [ ] Heartburn [ ] Diarrhea [ ] Rectal Bleeding [ ] Vomiting [ ] None [ ] Other: _____
Skin:	[ ] Rashes [ ] Lumps [ ] Nail change [ ] Dryness [ ] Color change [ ] Sore [ ] Hair loss [ ] Itching [ ] None [ ] Other _____
Neurological:	[ ] Vertigo [ ] Numbness [ ] Weakness [ ] Tingling [ ] Black out spells [ ] Dizziness [ ] Headaches [ ] Tremors [ ] Seizure [ ] None [ ] Other _____
Psychiatric:	[ ] Anxiety [ ] Memory Loss [ ] Depressed [ ] Hallucinations [ ] Tension [ ] Nervousness [ ] None [ ] Other _____
Urinary:	[ ] Urgency [ ] Frequent urination [ ] Decreased Stream [ ] Blood in urine [ ] Incontinence [ ] None [ ] Other _____
Blood:	[ ] Bruising [ ] Gingival Bleeding [ ] Thin blood [ ] None [ ] Other _____
Bone/Joint:	[ ] Joint pain [ ] Backache [ ] Stiffness [ ] Gout [ ] Swelling [ ] None [ ] Other _____
Endocrine:	[ ] Heat intolerance [ ] Cold intolerance [ ] Frequent Hunger [ ] High Blood sugar [ ] Sweating [ ] Thirst [ ] None [ ] Other _____