University of Kentucky
Gill Heart Institute
Initial Visit Information

I. Medical History

A. Current medical problem or reason for today's visit:

_____

B. List medications you are currently taking (Prescribed, Over-the-counter, and Herbal)

MEDICATION	DOSE	HOW MANY TIMES PER DAY?

C. Are you allergic to any medications? Yes ☐ No ☐

1. If yes, please list: _____

D. Family History/Medical History

1. Have you or anyone in your family had any of the following:

DISORDER	YES	NO	SELF	FAMILY MEMBER (List)
Obesity				
High blood pressure				
Stroke				
Heart disease				
High cholesterol				
Thyroid disease				
Diabetes				
Cancer				
Kidney disease				
Lung disease				

E. Review of Body Systems

SYMPTOM	YES	NO	COMMENTS
Head, Eyes, Ears, Nose, and Throat			
Frequent headaches			
Fainting or dizziness			
Other:			

SYMPTOM	YES	NO	COMMENTS
Heart and Lungs			
Chest pain / pressure			
Rapid or irregular heart beat			
Swelling of legs and/or feet			
Shortness of breath			
Cough			
Other:			
Gastrointestinal Tract			
Indigestion or heartburn			
Nausea or vomiting			
Abdominal bloating			
Abdominal pain			
Constipation			
Diarrhea			
Urinary Tract			
Poor bladder control			
Night-time urination, frequency			
Blood in urine			
Reproductive (women only)			
Date of last menstrual period			
Complications during pregnancy or delivery			
Plans to get pregnant within next 6 months?			
Lumps in breast			
Date of last mammogram			
Reproductive (men only)			
Erectile Dysfunction			
Other:			
Musculoskeletal			
Joint pain or swelling			
Back pain			
Leg cramps			
Neurological			
Stroke			
Seizures			
Other:			
Blood / Hematologic			
Bleeding problems			
Blood disorders such as Leukemia			
Other:			
Skin / Dermatologic			
Changes in color			
Rash			
Sores that won't heal			
Other:			

SYMPTOM	YES	NO	COMMENTS
Heart and Lungs			
Chest pain / pressure			
Rapid or irregular heart beat			
Swelling of legs and/or feet			
Shortness of breath			
Cough			
Other:			
Gastrointestinal Tract			
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Bleeding problems			
Blood disorders such as Leukemia			
Other:			
Skin / Dermatologic			
Changes in color			
Rash			
Sores that won't heal			
Other:			

SYMPTOM	YES	NO	COMMENTS
Other			
Difficulty sleeping			

F. Have you ever been hospitalized, had any surgeries or devices implanted? Yes ☐ No ☐
   1. If yes, complete the following:

REASON/SURGERIES	DATE(S)

II. Social History

A. Are you married? Yes ☐ No ☐

B. Do you or have you ever used tobacco? Yes ☐ No ☐
   1. If yes, how much? _____ How long? _____
   2. If you quit, when? _____

C. Do you drink alcohol-containing beverages? Yes ☐ No ☐
   1. If yes, how much? _____ How long? _____

D. Do you drink caffeine-containing beverages? Yes ☐ No ☐
   1. If yes, how much? _____ How long? _____

E. Do you exercise? Yes ☐ No ☐
   1. If yes, list activities: _____
   2. Frequency: _____ Duration: _____

F. Are you on any special diet? Yes ☐ No ☐
   1. If yes, what type(s): _____

III. Stress Assessment

A. Rate your level of stress over the last 12 months (circle the appropriate number)

1 2 3 4 5 6 7 8 9 10

Low ..... Moderate ..... High

B. Rate your level of stress over the last 30 days

1 2 3 4 5 6 7 8 9 10

Low ..... Moderate ..... High

C. How do you relieve tension and stress? _____

_____

_____

_____

D. Please answer the following questions:

Question	Yes	No	Comments
Are you happy with your life?			
Are you in good spirits most of the time?			
Do you think that most people are better off than you are?			

IV. Any additional pertinent information that your health care providers should know:

_____

_____

_____

_____

V. Contacts and Telephone Numbers:

A. Preferred Pharmacy: _____

1. Telephone Number: _____
2. Do you use mail order prescriptions? Yes ☐ No ☐
   a. If so, which prescriptions? _____

B. Cardiologist: _____

1. Address: _____

   _____
2. Telephone Number: _____ FAX: _____

C. Primary Care Physician: _____

1. Address: _____

   _____
2. Telephone Number: _____ FAX: _____

D. Insurance: _____

1. ID Number: _____ Group Number: _____
2. Address: _____

   _____
3. Telephone Number: _____ FAX: _____
4. Other Insurance: _____

Reviewed by: _____ Date: _____
Provider