St. Luke's Hospital

Valve Clinic

Name:	Date of Birth:	Date of Visit:
Physician(s):		

Past Medical History:

1)	9)
2)	10)
3)	11)
4)	12)
5)	13)
6)	14)
7)	15)
8)	16)

Surgical History/Hospitalizations:

Type of Operation/Reason for Hospitalization	Date (Or age at the time)

Medications: (Include over the counter medications)

Medication	Strength	# Pills per Dose	# Times per Day	Medication	Strength	# Pills per Dose	# Times per Day

Name: _____

Allergies: **Reaction:**

Social History:

Tobacco	☐ Never Tobacco ☐ Former Tobacco quit when: ☐ Current Tobacco packs per day: years smoking:
Drugs	☐ Never ☐ Yes type/frequency:
Alcohol	☐ No ☐ Yes drinks per day/week
Marital Status	☐ Single ☐ M.arried ☐ Separated ☐ Divorced ☐ Widowed
Live with	
Support System (family...)	
Occupation	

Family Medical History:

	Heart disease	Diabetes	Stroke	Cancer	Sudden Death	Bleeding problem	Clotting problem	Aneurysm	Age of death
Mother									
Father									
Brother(s)									
Sister(s)									
Children									

Name: _____

Review of systems: Please circle **Yes** next to the options that you have experienced recently.

Constitutional

Fever	Yes	No
Night Sweats	Yes	No
Fatigue	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No

Eyes

Change in vision	Yes	No
Glaucoma	Yes	No
Cataract	Yes	No

ENT

Diminished hearing	Yes	No
Hoarse voice	Yes	No
Nose bleeds	Yes	No
Sinus problems	Yes	No

Cardiovascular

Chest pain	Yes	No
Leg pain w/ walking	Yes	No
Shortness of breath	Yes	No
Swelling in legs	Yes	No
Palpitations	Yes	No
Fainting	Yes	No
Lightheadedness	Yes	No
Heart Attack	Yes	No
Heart murmur	Yes	No

Gastrointestinal

Blood in stool	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Difficulty swallowing	Yes	No
Heartburn	Yes	No
Nausea	Yes	No
Ulcers	Yes	No
Reflux/hiatal hernia	Yes	No
Colon problems	Yes	No

Genitourinary

Blood in urine	Yes	No
Painful urination	Yes	No
Incontinence	Yes	No
Frequent Urination	Yes	No
Kidney problems	Yes	No
Erectile dysfunction	Yes	No
Waking to urinate	Yes	No

Musculoskeletal

Neck pain	Yes	No
Gout	Yes	No
Back pain	Yes	No
Muscle pain	Yes	No
Arthritis	Yes	No

High cholesterol	Yes	No
Hypertension	Yes	No

Respiratory

Cough	Yes	No
Coughing up blood	Yes	No
Shortness of breath	Yes	No
Wheezing/asthma	Yes	No
Snoring	Yes	No
Sleep apnea	Yes	No
Emphysema	Yes	No

Skin

Itching	Yes	No
Rash	Yes	No
Skin cancer	Yes	No
Open sores	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disease	Yes	No

Hematology/Oncology

Bruising	Yes	No
Bleeding	Yes	No
Anemia/Blood disorder	Yes	No
Clotting problems	Yes	No

Psychiatric

Depression	Yes	No
Memory problem	Yes	No
Anxiety	Yes	No
Problem sleeping	Yes	No

Neurology

Headache	Yes	No
Seizure	Yes	No
Stroke/TIA	Yes	No
Imbalance	Yes	No
Confusion	Yes	No
Numbness	Yes	No
Tingling	Yes	No

Name: _____