Cardiovascular Center, P.A.
Dr. M. R. Lakshmi Narasimhan M.D.
264 Memorial drive Jacksonville, NC 28546
Phone: (910) 455-7001 Fax: (910)455-9778 Phone: 910) 455-0578

MEDICAL HISTORY QUESTIONAIRE

PATIENT NAME: **DOB:**

Have you previously been diagnosed with any of the following:

Respiratory:

Asthma	YES / NO
COPD	YES / NO
Pulmonary Hypertension	YES / NO
Pulmonary Embolism	YES / NO
Emphysema	YES / NO
Sleep Apnea	YES / NO

Other: _____

Gastro:

Acid Reflux	YES / NO
GI Bleed	YES / NO
Hernia	YES / NO
Hemorrhoid	YES / NO
Peptic Ulcer Disease	YES / NO
Ulcer	YES / NO
Irritable Bowel Syndrome	YES / NO
Diverticulitis	YES / NO
Jaundice	YES / NO

Other: _____

Neurology:

Migraines	YES / NO
Neuropathy	YES / NO
CVA/Stroke	YES / NO
TIA	YES / NO
Seizures	YES / NO
Syncope	YES / NO

Other: _____

Cardio:

AICD or Pacemaker	YES / NO
Heart valve disorder	YES / NO
Coronary Artery Disease	YES / NO
Heart Attack	YES / NO
High cholesterol	YES / NO
Hypertension	YES / NO
Arrhythmias	YES / NO
Congestive Heart Failure	YES / NO
Heart murmur	YES / NO
Cardiomyopathy	YES / NO
Deep Vein Thrombosis	YES / NO
Peripheral Artery Disease	YES / NO
Stents	YES / NO
Coronary Artery Bypass Graft	YES / NO

Other: _____

Musculoskeletal:

Arthritis	YES / NO
Degenerative Disk Disease	YES / NO
Fibromyalgia	YES / NO
Gout	YES / NO
Restless leg syndrome	YES / NO
Scoliosis	YES / NO
Carpal Tunnel	YES / NO
Chronic Pain	YES / NO

Other: _____

Malignancy:

Caner YES / NO

Specify: _____

Psychiatric:

Anxiety	**YES / NO**
Depression	**YES / NO**
PTSD	**YES / NO**
Other: _____	

ENT:

Glaucoma	**YES / NO**
Cataracts	**YES / NO**
Deafness	**YES / NO**
Corrective Lenses	**YES / NO**
Sinusitis	**YES / NO**
Legally Blind	**YES / NO**
Other: _____	

Hematology:

Anemia:	**YES / NO**
Other: _____	

Endocrine:

Diabetes	**YES / NO**
Thyroid Disorder	**YES / NO**
Hyperglycemia	**YES / NO**
Hypoglycemia	**YES / NO**
Other: _____	

Urinary:

Enlarged Prostate	**YES / NO**
Renal Failure	**YES / NO**
Kidney Problems	**YES / NO**
Dialysis	**YES / NO**
Other: _____	

FAMILY HISTORY

Is there any family history of any of the following diagnosis in your family. If yes, please indicate their relationship to you, whether they are living or deceased and their age presently or their age at death and the cause of death.

[ ] CAD / Who: _____

[ ] Congestive Heart Failure / Who: _____

[ ] Cardiomyopathy / Who: _____

[ ] Hypertension / Who: _____

[ ] Heart Attack/ Who: _____

[ ] Diabetes/ Who: _____

[ ] High Cholesterol/ Who: _____

[ ] Stroke / CVA/ Who: _____

[ ] Sudden Death/ Who: _____

[ ] Kidney Problems/ Who: _____

[ ] Emphysema/ Who: _____

[ ] Cancer/ Who: _____

SOCIAL HISTORY

Tobacco Use: YES / NO / NEVER **IF YES,** Smoke / Chew AMOUNT: _____ PER DAY **IF QUIT,** HOW LONG: _____

Alcohol Use: YES / NO / NEVER **IF YES,** SOCIALLY / OCCASSIONALLY / RARELY

Illegal Drug Use: YES / NO / NEVER IF YES, WHAT TYPE: _____ HOW OFTEN: _____

Please list all ALLERGIES:

Please list all SURGERIES:

Please list all current MEDICATIONS: (include dose and how often taken, as well as any over the counter medicines)

In the past 3-6 months have you experienced any of the following signs or symptoms:

ENT:

runny nose	YES / NO
sinusitis	YES / NO
nose bleeds	YES / NO
fatigue	YES / NO
decreased hearing	YES / NO
ringing in ears	YES / NO
vertigo	YES / NO
nasal congestion	YES / NO
sneezing	YES / NO
difficulty swallowing	YES / NO
hoarseness	YES / NO

other: _____

EYES:

excessive watering	YES / NO
blurred / double vision	YES / NO
change in vision	YES / NO
spots	YES / NO
floaters	YES / NO
legally blind	YES / NO

other: _____

SKIN:

bruise easily	YES / NO
rashes	YES / NO
lumps	YES / NO
itching	YES / NO
discoloration	YES / NO
mole abnormalities	YES / NO

other: _____

RESPIRATORY:

shortness of breath	YES / NO
asthma	YES / NO
COPD	YES / NO
History of Smoking	YES / NO
Excessive Cough	YES / NO
Wheezing	YES / NO

Other: _____

GASTRO:

abdominal pain	YES / NO
nausea	YES / NO
vomiting	YES / NO
change in bowel movements	YES / NO
heartburn	YES / NO
dark stools	YES / NO
change in appetite	YES / NO
weight change	YES / NO
bloating	YES / NO
constipation	YES / NO
diarrhea	YES / NO
hemorrhoids	YES / NO
indigestion	YES / NO
rectal bleeding	YES / NO

Other: _____

URINARY:

blood in urine	YES / NO
difficulty urinating	YES / NO
frequent urination	YES / NO
enlarged prostate	YES / NO
renal insufficiency	YES / NO

other: _____

MUSCULOSKELETAL:

arthritis	YES / NO
difficulty walking or limited exercise	YES / NO
muscle weakness	YES / NO
muscle pains	YES / NO
limited motion	YES / NO
joint pain	YES / NO
stiffness	YES / NO

other: _____

PSYCHIATRIC:

depression	YES / NO
mood swings	YES / NO
insomnia	YES / NO

Other: _____

NEURO:

dizziness	YES / NO
headache	YES / NO
fainting	YES / NO
hemiparesis	YES / NO
numbness	YES / NO
tingling	YES / NO
tremors	YES / NO
seizure	YES / NO
slurred speech	YES / NO
balance problems	YES / NO

other: _____

CARDIO:

chest pain	YES / NO
chest pressure	YES / NO
chest discomfort	YES / NO
chest tightness	YES / NO
swelling in hands or feet	YES / NO
history of heart attack	YES / NO
hypertension	YES / NO
palpitations	YES / NO
irregular heart beat/rate	YES / NO
high cholesterol	YES / NO

other: _____

ENDOCRINE:

excessive thirst	YES / NO
excessive sweating	YES / NO
excessive urination	YES / NO
excessive hunger	YES / NO

other: _____