SWEDISH
HEART & VASCULAR
INSTITUTE

SWEDISH HEART & VASCULAR EDMONDS
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Today's Date _____ *Active on* ***MyChart:*** ☐ *No* ☐ *Yes*

PATIENT HISTORY

Last Name	*First Name*	*Middle Initial*

Date of Birth	*Referring MD*

HISTORY

Chief Complaint (Reason for your visit)

Do you want us to correspond with you through MyChart ? (email through our electronic medical records system) ☐ *No* ☐ *Yes*

MEDICAL HISTORY

Patient Medical History

Diabetes _____ Yes No
High blood pressure _____ Yes No
High cholesterol _____ Yes No
Heart disease _____ Yes No
Heart murmur _____ Yes No
Abnormal heart rhythm _____ Yes No
Stroke _____ Yes No
Sleep apnea _____ Yes No
Kidney disease _____ Yes No
COPD/emphysema/asthma _____ Yes No

Past Cardiovascular Testing and Procedures:

Coronary Angioplasty and/or Stent _____ Yes No
Heart Surgery _____ Yes No
Heart Rhythm Study/Ablation _____ Yes No
Pacemaker or Defibrillator _____ Yes No
Carotid Artery Surgery, Leg Artery Surgery _____ Yes No

Patient Social History

Use of Tobacco ☐ Never ☐ Former ☐ Current
Packs per day _____ # Years _____
Use of Smokeless Tobacco ☐ Never ☐ Former ☐ Current
Use of Cannabis ☐ Never ☐ Occasional ☐ Regular

Use of Alcohol ☐ Never Drinks per week _____
Use of Drugs ☐ Never ☐ Former
Type/Frequency _____

Medication Allergies

Medication	Reaction

MD Signature _____ Date of Review _____

Patient Name _____ **Date of Birth** _____

FAMILY HISTORY

☐ Heart disease Relation _____ Age of onset _____

☐ Diabetes Mellitus Relation _____ Age of onset _____

REVIEW OF SYSTEMS

• Constitutional Symptoms

Fever ..... Yes No

Weight loss ..... Yes No

• Skin

Rash ..... Yes No

Itching ..... Yes No

• HENT

Nose bleeds ..... Yes No

Sore throat ..... Yes No

• Eyes

Blurred vision ..... Yes No

Double vision ..... Yes No

• Cardiovascular

Chest pain, angina pectoris or chest tightness ..... Yes No

Palpitations ..... Yes No

Shortness of breath with lying flat ..... Yes No

Pain in leg muscles with walking ..... Yes No

Ankle/foot swelling ..... Yes No

• Respiratory

Shortness of breath ..... Yes No

Wheezing ..... Yes No

• Gastrointestinal

Nausea or Vomiting ..... Yes No

Abdominal pain ..... Yes No

Blood in stool ..... Yes No

• Genitourinary

Pain with urinating ..... Yes No

Blood in urine ..... Yes No

• Musculoskeletal

Muscle pain ..... Yes No

Falls ..... Yes No

• Endocrine/Hematology/Allergy

Easy bruise/bleed ..... Yes No

Excessive thirst ..... Yes No

• Neurological

Dizziness ..... Yes No

Headache ..... Yes No

Loss of consciousness ..... Yes No

• Psychiatric

Insomnia ..... Yes No

Memory loss ..... Yes No

MD Signature _____ Date of Review _____