Baseline History and Physical

Patient:

Date:_____

Occupation: _____

Presenting Problem:_____
_____
_____

HPI: (Symptoms)

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CNS: ❍numbness ❍ paralysis ❍ speech disturbance ❍ amaurosis
CVS: ❍ exertional chest pain: CCS grade ___/IV ❍ resting angina ❍ nocturnal angina
❍ SOB grade _____/IV ❍ orthopnea ❍ pnd: ❍ edema ❍claudication ____blocks
❍ palpitations ❍ dizziness ❍ syncope
RS: ❍ cough ❍ sputum ❍ hemoptysis ❍ wheezing ❍ asthma
GI: ❍ heartburn ❍ gas ❍ indigestion ❍ dysphagia ❍ reflux
GU: ❍ nocturia ❍ frequency
Hem: ❍ bleeding ❍ bruising
MSK: ❍ myalgia
Other:_____
_____
_____
_____

Key: ● condition present ∅ condition absent ❍ not asked/assessed

Baseline History and Physical

Cardiac History	Yes	No	Date(y/m/d)	Duration/Location/Procedure/Institution
Stable Angina				
Unstable Angina				
Previous MI				
Cath				
Previous PTCA				
Previous CABG				
Valve Surgery				
Other				

Risk Factors	Y	N	Duration	Therapy	Control
Hypertension					
Diabetes					
Hyperlipidemia					
Smoking					
Family history of premature CHD in 1° relative (M ≤ 55/ F ≤ 65)					

PMH: ❍ CVA_____ ❍ TIA_____ ❍ Rheumatic fever ❍ heart murmur
❍ PUD ❍ Hiatus Hernia ❍ TB ❍ SBE ❍ Bleeding disorder ❍ Cancer
Other_____
_____
_____
_____

Allergies: ❍None /_____ Coffee/Tea:____cups/day Alcohol:_____/day/week

Medications:	Agent	Dose	Adjustment
ASA			
Other platelet inhibitor			
Coumadin			
Digoxin			
Diuretic			
Beta-blocker			
Calcium channel blocker			
Nitrate			
ACE-I			
A-II receptor blocker			
Statin			
Fibrate			
Ezetimibe			
Oral hypoglycemic 1			
Oral hypoglycemic 2			
Oral hypoglycemic 3			
Insulin			

Key: ● condition present ∅ condition absent ❍ not asked/assessed