Florida Cardiopulmonary Center
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Florida Amputation Prevention Institute

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PLEASE FILL OUT ALL PAGES AS COMPLETELY AS POSSIBLE.

Name_____ Date of Birth_____Age_____
Date_____ Referring Physician_____

CHIEF COMPLAINTS:

_____

PAST MEDICAL HISTORY (HAVE YOU HAD THESE?)

CARDIAC:
Coronary Artery Disease YES____NO_____
Heart Attack YES____NO_____
Coronary Artery Stent YES____NO_____
Heart Catheterization YES____NO_____
Heart Bypass Surgery YES____NO_____
Hypertension YES____NO_____
Congestive Heart Failure YES____NO_____

ENDOCRINE:
Diabetes YES____NO_____
High Cholesterol YES____NO_____
Hypothyroidism YES____NO_____
Hyperthyroidism YES____NO_____

NEOROLOGICAL:
Stroke YES____NO_____
Epilepsy YES____NO_____

VASCULAR:
Peripheral Vascular Disease YES_____NO
Carotid Artery Disease YES_____NO
Varicose Veins YES_NO_____

RESPIRATORY:
Bronchial Asthma YES____NO_____
Pneumonia YES____NO_____
Emphysema YES____NO_____
Lung Cancer YES____NO_____
Sleep Apnea YES____NO_____

GASTRINTESTINAL:
Peptic Ulcer Disease YES____NO_____
Hepatitis YES_____NO
Irritable Bowel Syndrome YES___NO_____
Ulcerative Colitis YES_NO_____
Crohn's Disease YES____NO_____

UROLOGICAL:
Kidney Stones YES_____NO
Chronic Kidney Disease YES_____NO
Benign Prostatic Hypertrophy YES_NO_____

OTHERS:
Arthritis YES____NO_____
Bleeding Disorders YES____NO_____
Cancer YES____NO_____

LIST ANY OTHER DISEASES:

_____

_____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

_____

_____

ALLERGIES (TO THE FOLLOWING MEDICATIONS, PLEASE CHECK)

PENICILLIN_____SULFA_____ASPRIN_____SHELLFISH_____IV DYE_____

OTHER MEDICATIONS:

_____

PLEASE SPECIFY REACTION TO ABOVE MEDICATIONS: _____

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

FAMILY MEDICAL HISTORY (Has any blood relative ever had?)

	YES	NO	WHO		YES	NO	WHO
Diabetes	_____		_____	Cancer	_____	_____	_____
High Blood Pressure	_____	_____	_____	Stroke	_____	_____	_____
Heart Disease	_____	_____	_____	Abnormal Bleeding	_____	_____	_____

SOCIAL HISTORY

Female Patients: Are you pregnant or do you think you are pregnant? YES_____NO_____

Married_____Single_____ Divorced_____Widowed_____Separated_____

TOBACCO USE

Are your currently using tobacco? YES_____NO_____#packs per day_____for how many years_____

How long after you wake up do you smoke your first cigarette? _____

How ready you are to quit? (check one)_____Ready to quit?_____Thinking about quitting? _____

Not ready to quit? Did you use tobacco in the past? YES_____NO_____# packs per day_____for how many years_____

Date you quick_____

ALCOHOL USE

Do you use alcohol regularly? YES_____NO_____How much per day for how many years? Did you use tobacco in the past? YES_____NO_____How much per day for how many?_____Date you quit_____

Exercise

Do you exercise regularly? YES_____NO_____How much?_____

REVIEW OF SYSTEMS

CARDIAC:

Shortness of Breath	YES____ NO_____
Chest Pain	YES_____NO_____
Heart Palpitations	YES_____NO_____
Dizziness, Fainting	YES_____NO_____
Ankle Swelling	YES_____NO_____

ENDOCRINE:

Excessive Thirst	YES_____NO_____
Increased Urination	YES_____NO_____
Heat or Cold Intolerance	YES_____NO_____
Rising to void, more than once per night	YES_____NO_____

NEUROLOGICAL:

Severe Headaches	YES____ NO_____
Confusion	YES_____NO_____
Weakness in Arm/Leg	YES____ NO_____
Transient Blindness	YES_____NO_____

VASCULAR:

Calf Pain on Ambulation	YES_____NO_____
Numbness/ Tingling in Feet	YES_____NO_____

RESPIRATORY:

Cough	YES____ NO_____
Spitting of Blood	YES_____NO_____
Wheezing	YES_____NO_____

GASTROINTESTINAL:

Abdominal Pain or Heartburn	YES_____NO_____
Nausea, Vomiting	YES_____NO_____
Diarrhea	YES_____NO_____
Constipation	YES_____NO_____

GENERAL REVIEW:

Weight Change	YES_____NO
Extreme Fatigue	YES_____NO
Fever	YES_NO_____
Joint Pains	YES_____NO____
Excessive Bruising	YES____ NO_____
Impaired Sight	YES____ NO_____
Nose Bleed	YES_____NO_____
Anxiety	YES____ NO____