FCC 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____