F 1 0 9 0 0

CURRENT HEALTH PROBLEMS

Do you currently have or have you recently had the following?
(Circle "Y" or "N", no response if uncertain)

General

Y / N Chronic sense of fatigue
Y / N Poor appetite
Y / N Weight loss not due to dieting
Y / N Fever or night sweats
Y / N Anemia

Skin

Y / N Skin rash
Y / N Itching
Y / N New growth or changing mole

Eyes/Ears/Nose/Throat

Y / N Trouble seeing, uncorrected by eye glasses
Y / N Hearing loss
Y / N Nosebleed
Y / N Infected teeth or gums

Cardio-Respiratory System

Y / N Frequent Coughing
Y / N Coughing up blood
Y / N Wheezing
Y / N Stop breathing while asleep
Y / N Shortness of breath
Y / N Chest or arm pain or pressure
Y / N Racing heart rhythm
Y / N Irregular heart rhythm
Y / N Fainting or near fainting
Y / N Swelling of ankles
Y / N Discomfort in calf of leg triggered by walking

Digestive System

Y / N Abdominal pain or distress
Y / N Frequent heartburn
Y / N Difficult or painful swallowing
Y / N Bleeding from stomach / bowel
Y / N Nausea or vomiting
Y / N Change in bowel function
Y / N Frequent diarrhea
Y / N Frequent constipation

Urinary System

Y / N Blood in urine
Y / N Pain on urination
Y / N Difficulty passing urine
Y / N Frequent urination at night

Musculo-Skeletal System

Y / N Hernia
Y / N Muscle weakness or aching
Y / N Painful or stiff joints
Y / N Back or neck trouble

Nervous System/Psychological

Y / N Severe headaches
Y / N One sided weakness / numbness
Y / N Transient: Confusion or impairment of vision or of speech
Y / N Memory loss
Y / N Numbness or burning of feet
Y / N Often feel anxious
Y / N Often discouraged or depressed

Breasts

Y / N Lumps
Y / N Discharge

GYN-OB

Y / N Are you possibly pregnant?
Y / N Heavy menstrual bleeding?
Y / N Are you post menopause?
Y / N Abnormal bleeding?

NUMBER OF: Pregnancies: _____
Miscarriages _____ Births _____

SURGERY/PROCEDURES

Indicate surgery or procedures undergone by placing a check mark. Specify year(s) surgery or procedure took place.

Year(s)

- ❑ Heart angiogram
- ❑ Angioplasty or stent
- ❑ Coronary bypass
- ❑ Heart valve surgery
- ❑ Appendix
- ❑ Gallbladder surgery
- ❑ Hysterectomy
- ❑ Mastectomy
- ❑ Prostate surgery
- ❑ Varicose vein surgery
- ❑ Other surgery:

_____
_____
_____
_____

Have you had complications from surgery or other procedures? Y / N
if "Y" explain:

_____
_____

ALLERGIES:

PENICILLIN Y / N
SULFA Y / N
OTHER ALLERGIES Y / N
SPECIFY:

_____
_____

PLEASE LIST MEDICATIONS: Include nonprescription medications & dosages if known.

1 _____ 6 _____
2 _____ 7 _____
3 _____ 8 _____
4 _____ 9 _____
5 _____ 10 _____

PLEASE COMPLETE BOTH SIDE OF THIS SHEET

LOMA LINDA UNIVERSITY HEALTH CARE

PAST HISTORY & INVENTORY BY SYSTEMS II
LOMA LINDA INTERNATIONAL HEART INSTITUTE

F10900 (8-11)

PATIENT IDENTIFICATION
Name:
Birth Date:
MR No.:

MEDICAL HISTORY (circle "Y" or "N", no response if uncertain):

Have you ever had?		Year first occurred
Y / N	High blood pressure	
Y / N	Diabetes	
Y / N	High cholesterol	
Y / N	Heart attack	
Y / N	Cardiac arrest	
Y / N	Heart failure	
Y / N	Atrial fibrillation	
Y / N	Rheumatic fever	
Y / N	Aneurysm of aorta	
Y / N	Phlebitis (clotted vein)	
Y / N	Blood clot in lung	
Y / N	Stroke	
Y / N	Bleeding tendency	
Y / N	Bleeding of stomach or of bowel	

Have you ever had?		Year first occurred
Y / N	Ulcer of stomach or duodenum	
Y / N	Ulcerative colitis or Chron's disease	
Y / N	Diabetic eye problem	
Y / N	Blood transfusion	
Y / N	Asthma	
Y / N	Convulsions/seizures	
Y / N	Autoimmune disorder	
Y / N	Gout	
Y / N	Radiation therapy	
Y / N	Chemotherapy	
Y / N	Cancer (state type): _____ _____	

Have you ever had?		Year first occurred
Y / N	Gallbladder trouble	
Y / N	Pancreatitis	
Y / N	Hepatitis/liver disease	
Y / N	HIV infection	
Y / N	Kidney disease	
Y / N	Kidney stone	
Y / N	Nervous breakdown	
Y / N	Osteoporosis	
Y / N	Polio	
Y / N	Thyroid trouble	
Y / N	Tuberculosis	
Y / N	Other serious illnesses or injuries (specify): _____ _____	

SOCIAL HISTORY

Age _____ Sex _____ Birthplace _____

Nationality _____ Religion _____

Occupations _____

Marital status _____ Health of spouse _____

Number of living children _____

In what town do you live? _____

With whom do you live? Alone _____ Spouse _____

Children _____ Parent(s) _____ Other _____

Have you used any of the following? Circle "Y or "N".

Intravenous drugs Y / N Cocaine Y / N

Amphetamines Y / N Marijuana Y / N

Smoking history (place check (✓) mark):

- ❑ Never smoked
- ❑ Former smoker, specify when stopped _____
- ❑ Current smoker

Alcohol and tobacco, average amount per day:

Alcohol amount and type _____

Cigarettes, packs/day _____

Other tobacco (type) _____

Caffeine containing beverages, cups or servings per day:

Coffee _____ Tea _____ Soft drinks _____

Has your use of alcohol ever been of concern to you? Y / N

FAMILY HISTORY

Your father (place check (✓) mark): ❑ Living ❑ Deceased

If deceased: age at death _____ cause of death _____

Your mother (place check (✓) mark): ❑ Living ❑ Deceased

If deceased: age at death _____ cause of death _____

HAS ANY BLOOD RELATIVE HAD THESE PROBLEMS? (Circle "Y" or "N", no response if uncertain)		HOW PERSON(S) IS RELATED TO YOU
Y / N	Diabetes	
Y / N	High blood pressure	
Y / N	Coronary disease or heart attack	
Y / N	Other heart problem	
Y / N	Heart trouble before age of 60 years	
Y / N	Stroke	
Y / N	Kidney disease	
Y / N	Colon cancer	
Y / N	Breast cancer	

Identify other medical disorders which may run in your family:

_____

Name: _____

Date: _____

PLEASE COMPLETE BOTH SIDE OF THIS SHEET

FOR PHYSICIAN USE I reviewed the information on both sides of this sheet.

Date: _____ Signature: _____

PATIENT IDENTIFICATION

Name:

Birth Date:

MR No.: