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**HISTORY AND PHYSICAL/CONSULTATION FORM**

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Referring Physician/Other Treating Physicians \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL INFORMATION**

Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ Employment Status: \_\_\_\_\_ Employed \_\_\_\_\_ Retired \_\_\_\_\_ Disabled \_\_\_\_\_

Occupation \_\_\_\_\_ If disabled, what reason? \_\_\_\_\_

**CHIEF COMPLAINT: (Reason for today's visit)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST HOSPITALIZATIONS & SURGERIES (Hospitalizations and surgical procedures.)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CHILDHOOD & ADULT DISEASES: Have you had any of the following diseases diagnosed?**

Please list your childhood illnesses: \_\_\_\_\_

**Adult illnesses:**

- |                          |                |                    |                       |                      |
|--------------------------|----------------|--------------------|-----------------------|----------------------|
| ____ asthma              | ____ pneumonia | ____ tuberculosis  | ____ thyroid disorder | ____ kidney failure  |
| ____ bronchitis          | ____ emphysema | ____ hepatitis     | ____ high cholesterol | ____ rheumatic fever |
| ____ diabetes            | ____ cancer    | ____ heart disease | ____ blood disorders  | ____ blood clots     |
| ____ high blood pressure |                |                    |                       |                      |

Other Illnesses:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*Positive and negative responses reviewed and confirmed.**

\_\_\_\_\_ M.D. initials



Patient name \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please check if you are experiencing any of these symptoms.

**General:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ fever    \_\_\_\_\_ sweats    \_\_\_\_\_ weakness    \_\_\_\_\_ weight change    \_\_\_\_\_ anxiety/depression  
\_\_\_\_\_ chills    \_\_\_\_\_ fatigue    \_\_\_\_\_ insomnia    \_\_\_\_\_ irritability

**Skin:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ color changes    \_\_\_\_\_ skin eruptions    \_\_\_\_\_ itching    \_\_\_\_\_ scaling    \_\_\_\_\_ easy bruising

**Eyes:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ glasses    \_\_\_\_\_ color blindness    \_\_\_\_\_ blind spots    \_\_\_\_\_ redness/swelling    \_\_\_\_\_ excessive tearing  
\_\_\_\_\_ blurring    \_\_\_\_\_ night blindness    \_\_\_\_\_ double vision    \_\_\_\_\_ discharge    \_\_\_\_\_ sensitivity to light

**Ears:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ pain    \_\_\_\_\_ deafness    \_\_\_\_\_ ringing in ears    \_\_\_\_\_ dizziness    \_\_\_\_\_ itching    \_\_\_\_\_ discharge

**Nose:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ excessive bleeding    \_\_\_\_\_ nasal discharge    \_\_\_\_\_ sinusitis    \_\_\_\_\_ blockage

**Mouth:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ dentures    \_\_\_\_\_ abnormal taste    \_\_\_\_\_ cavities    \_\_\_\_\_ gum disease    \_\_\_\_\_ speech difficulty    \_\_\_\_\_ hoarseness

**Neck:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ swelling    \_\_\_\_\_ pain    \_\_\_\_\_ goiter    \_\_\_\_\_ stiff neck    \_\_\_\_\_ masses/nodes

**Respiratory:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ cough    \_\_\_\_\_ sputum production    \_\_\_\_\_ wheezing    \_\_\_\_\_ coughing up blood    \_\_\_\_\_ shortness of breath

**Cardiovascular:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ irregular or fast heart beat    \_\_\_\_\_ chest pain    \_\_\_\_\_ dizziness    \_\_\_\_\_ pain in calves    \_\_\_\_\_ swelling

**Gastrointestinal:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ tooth or gum disease    \_\_\_\_\_ belching    \_\_\_\_\_ heartburn    \_\_\_\_\_ abdominal pain    \_\_\_\_\_ mucous in stools  
\_\_\_\_\_ difficulty chewing    \_\_\_\_\_ bloating    \_\_\_\_\_ constipation    \_\_\_\_\_ jaundice    \_\_\_\_\_ black/tarry stools  
\_\_\_\_\_ difficulty swallowing    \_\_\_\_\_ vomiting    \_\_\_\_\_ diarrhea    \_\_\_\_\_ bloody stools    \_\_\_\_\_ rectal pain

**Genitourinary:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ difficulty urinating    \_\_\_\_\_ painful urination    \_\_\_\_\_ How many times do you have to urinate during the night?  
\_\_\_\_\_ incontinence (leaking)    \_\_\_\_\_ kidney stones    \_\_\_\_\_ blood in urine

WOMEN: date of last menstrual period \_\_\_\_\_

**Endocrine:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ thyroid disorder    \_\_\_\_\_ goiter    \_\_\_\_\_ feel hot or cold when others are not affected

**Neurological:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ frequent headaches    \_\_\_\_\_ partial/temporary loss of vision    \_\_\_\_\_ numbness/tingling of face    \_\_\_\_\_ seizures  
\_\_\_\_\_ severe headaches    \_\_\_\_\_ partial/temporary loss of speech    \_\_\_\_\_ weakness of arms/legs  
\_\_\_\_\_ memory change

**Musculoskeletal:** \_\_\_\_\_ **No problems**

\_\_\_\_\_ limitation of movement of joints    \_\_\_\_\_ swelling of joints    \_\_\_\_\_ tenderness of bones or joints    \_\_\_\_\_ backache

Other:

\_\_\_\_\_  
\_\_\_\_\_

\*Positive and negative responses reviewed and confirmed.

\_\_\_\_\_ M.D. initials