PATIENT HISTORY

Date:_____

First Name_____ **Middle Name**_____ **Last Name**_____
Occupation:_____ **Retired: Y or N**
Marital Status:_____
Referring Doctor:_____
Reason for Visit: What cardiac or vascular problems do you have?

PERSONAL HISTORY AND RISK FACTOR

Have you ever experienced or have been diagnosed with:

Congestive Heart failure	Yes	No	When? _____
Heart Attack (myocardial infarction)	Yes	No	When? _____
High Blood Pressure	Yes	No	When? _____
Diabetes	Yes	No	When? _____
Stroke	Yes	No	When? _____
High Cholesterol	Yes	No	When? _____
Cancer	Yes	No	When? _____
Lung Disease	Yes	No	When? _____
Kidney Problems	Yes	No	When? _____
Bleeding Tendencies	Yes	No	When? _____
Thyroid Disorder	Yes	No	When? _____
Peripheral Vascular Disease	Yes	No	When? _____
Heart Valve Disease	Yes	No	When? _____
Other Major Illness_____			When**?** _____

SURGERIES:

Heart Surgery Yes No When?_____
What Procedures?_____

Vascular Surgery Yes No When?_____
What Procedures?_____

Cardiovascular Procedures/Intervention Yes No When? _____
What Procedures?_____

OTHER SURGERIES:

Type:_____ When?_____
Type:_____ When?_____
Type:_____ When?_____
Type:_____ When?_____

FEMALES ONLY:

Have you had a total Hysterectomy (ovaries and uterus removed)? Yes No Age_____
Do You take Birth Control Pills? Yes No
Have you gone through Menopause? Yes No
Are You taking hormone replacements? Yes No

HABITS

DO YOU:

Use Tobacco Yes No How Much?_____
When did you quit?_____

Drink Alcohol Yes No How Much?_____
How Long?_____ When did you quit_____

Drink Caffeine Yes No How Much?_____
When did you quit?_____

Take Illicit Drugs Yes No How Much?_____
How Long?_____ When Did you quit?_____

List any problems with mobility or self care:_

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FAMILY HISTORY

Mother: Alive_____ Age_____ Deceased_____ age Deceased_____
Major Health problems**:**_____

Father: Alive_____Age_____ Deceased_____ age Deceased_____
Major Health problems_____

Brothers: Alive_____Ages:_____ Deceased_____ age Deceased_____
Major Health problems_____

Sisters: Alive_____Ages:_____ Deceased_____age Deceased_____
Major Health problems_____

Children: Alive_____Ages:_____ Deceased_____age Deceased_____
Major Health problems_____

Has any blood relative died suddenly? Yes____ No__Age_____ Relation_____

Allergies or intolerance to medications? Yes_____No____
Medication/Reaction:_____

Other Allergies (foods, adhesive tape, X-ray contrast dye, latex, etc). Yes_____ No_____
What/Reaction:_____

CURRENT MEDICATIONS

Drug	Dosage (mg)	How Many times per day?

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PATIENT HEALTH CHECKLIST

Check only the problems you frequently experience or have been treated for in the past:

Constitutional
_____Significant weight change
_____Night Sweats
_____Unexplained Fever

Eyes
_____Cataracts
_____Blurred or double vision
_____Glaucoma

ENMT
_____Difficulty swallowing
_____Dry, hoarse throat

Cardiovascular
_____Chest discomfort
_____Fluttering feeling in chest
_____Skipped Heartbeats
_____Swelling in ankles/feet

Respiratory
_____Wheezing
_____Chronic cough
_____Asthma
_____History of Tuberculosis
_____Shortness of breath

Gastrointestinal
_____Indigestion
_____Ulcers

Genitourinary
_____Loss of bladder control
_____Blood in urine

Comments:

Musculoskeletal
_____Arthritis
_____Back Pain
_____Muscle weakness

Integumentary
_____Skin Rash

Neurological
_____Headache
_____Memory Loss
_____Stroke
_____Speech problems

Psychological
_____Depression
_____Anxiety
_____Unusual stress
_____Eating disorder

Endocrine
_____Thyroid problems

Hematology/Lymphatic
Breast masses/lumps
Unexplained bruising

Allergic/Immunologic
_____Drug allergies
_____Mold, pollen, dust allergies

Other:_____

Physician Signature:_____ Date:_____