MEDICAL HISTORY Date ____ / _____ / _____

Name _____ Age _____ Birth Date _____ / _____ / _____
Address _____ Sex ☐ Male ☐ Female
_____ Home Phone (_____) _____
_____ Work Phone (_____) _____
Employer _____ Emergency Contact _____
Address _____ Phone (_____) _____
Work # _____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Care Physician:
Address: _____
Phone #: _____ Fax #: _____
Referring Physician, if different than above:
Address: _____
Phone #: _____ Fax # _____

ALLERGIES to MEDICATIONS, X-RAY DYES, or OTHER SUBSTANCES ☐ Yes ☐ No
(If yes, please list name of medications and type of reaction):

_____ _____ _____
_____ _____ _____
_____ _____ _____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS
Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain/ Chest Tightness
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Atrial Fibrillation
11. Rheumatic Fever
12. Asthma
13. Heart Rhythm Disturbance
14. Varicose Veins
15. Persistent Cough
16. Leg Pain
17. Leg Ulcers
18. Abdominal Discomfort/Bloating
19. Indigestion
20. Nausea/Vomiting
21. Stroke
22. Activity Intolerance
23. Fatigue/weakness
24. Blood in Stool
25. Stomach Ulcers
26. Wake up at night SOB
27. Unexplained Weight Gain/Loss
28. Sleep on > 2 Pillows
29. Gall Bladder Disease
30. Colitis
31. Hepatitis
32. Thyroid Disease
33. Headache
34. Kidney Disease
35. Arthritis
36. Low Back Problem
37. Blood Disorders
38. Anxiety
39. Depression
40. Anemia
41. Alcohol Abuse
42. Drug Abuse
43. Gout
44. Other _____
45. Other _____

PAST MEDICAL HISTORY: _____
_____
_____
_____

Please List and supply the dates of:
Operations: _____
_____
_____
_____

Hospitalizations other than for surgery _____
_____
_____
_____

Heart Procedures:

Heart Cath	❑ Yes ❑ No	Date _____	Location _____
Stent	❑ Yes ❑ No	Date _____	Location _____
Open Heart Surgery	❑ Yes ❑ No	Date _____	Location _____
Pacemaker	❑ Yes ❑ No	Date _____	Location _____
Defibrillator	❑ Yes ❑ No	Date _____	Location _____
EPS/Ablation	❑ Yes ❑ No	Date _____	Location _____

Vascular Procedures:

Carotid Endarterectomy	❑ Yes ❑ No	Date _____	Location _____
Carotid Stent	❑ Yes ❑ No	Date _____	Location _____
Kidney Stent	❑ Yes ❑ No	Date _____	Location _____
Leg Bypass	❑ Yes ❑ No	Date _____	Location _____
Leg Stent	❑ Yes ❑ No	Date _____	Location _____
Aneurysm	❑ Yes ❑ No	Date _____	Location _____

FAMILY HISTORY

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which Family Member?	Approximate Age When Diagnosed
Cancer (describe type)		
Hypertension (High Blood Pressure)		
Heart Disease		
Diabetes		
Strokes		
Aneurysm		
Bleeding Diseases		
Other: _____		

PRIOR TESTING

Echocardiogram	❑ Yes ❑ No	Date _____	Location _____
Stress Test	❑ Yes ❑ No	Date _____	Location _____
Holter Monitor	❑ Yes ❑ No	Date _____	Location _____
Hearth Cath	❑ Yes ❑ No	Date _____	Location _____

MEDICATIONS (PRESCRIPTION, OVER-THE- COUNTER, VITAMINS, HERBS, etc.)

Drug Name	Dose	Drug Name	Dose

PREVENTION

Do you smoke?	❑ Yes ❑ No	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	❑ Yes ❑ No	If yes, how much per week? _____
Do you drink caffeine?	❑ Yes ❑ No	If yes, how many cups per day? _____
Do you use drugs? (Marijuana, Cocaine, Crack, etc.)	❑ Yes ❑ No	If yes, explain _____