Medical History Form

Name: ________ Date of Birth___/___/___ Today's Date___/___/___

Your answer on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any questions, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you!

Present Health Concerns/ Reasons for Visit

_____
_____
_____
_____
_____
_____

Allergies □ Refer to Printed Medication List		
Drugs/ Substance	**Reactions**	**Date of Onset**

Problems		
Conditions <u>currently</u> being treated by physician	**Date of Onset**	**Physicians**

Prior Cardiac Testing/Procedures

Test/ Procedure	Date Performed	Results
Echo		
EKG		
Cardiac Catheterization		
Carotid Duplex (ultrasound of arteries in the neck)		
ABI/PVR (testing circulation to your legs)		
Stress Test ☐ Treadmill Only ☐ With Imaging		
Cardiovascular Surgery (specify type) _____		
Other (specify) _____		
Other (specify) _____		

History of Present Illness (Check all that apply to your visit today.)

Condition/ Symptoms	X	Condition/ Symptoms	X
Coronary Artery Disease		Palpitations	
Chest Pain		Syncope	
Myocardial Infarction (Heart Attack)		Cardiac Arrhythmias	
Coronary Artery Bypass Surgery (CABG)		Stroke or TIA	
Congestive Heart Failure (CHF)		Carotid Artery Disease	
Edema		Peripheral Artery Disease (PAD/PVD)	
Dyspnea (Shortness of Breath)		Heart Valve Disorder	

Risk Factors

Tobacco ☐ Never ☐ Quit: Date_____ ☐ Current Smoker: Packs/day_____ Years used____

Type of Tobacco: ☐ Chew ☐ Cigars ☐ Cigarettes ☐ Pipe ☐ Smokeless/ E-cigarettes

Diabetes ☐ No ☐ Yes: ☐ Type 1 or ☐ Type2 Year Diagnosed_____

Dyslipidemia (High Cholesterol) ☐ No ☐ Yes

Family History of Early CAD(Coronary Artery Disease) ☐ No ☐ Yes ☐ Unknown

Hypertension (High Blood Pressure) ☐ No ☐ Yes Year Diagnosed_____

Peripheral Vascular Disease (PVD/PAD) ☐ No ☐ Yes

Social History

Family
Marital Status_____ ☐ Previously Widowed

Children ☐ None #Sons_____ #Daughters_____

Lifestyle
Type Diet_____

Activity ☐ Moderate ☐ Sedentary

☐ Unable ☐ Vigorous

Advance Directive (Please provide copy of document.)

☐ None ☐ Do Not Resuscitate

☐ Healthcare provider ☐ Durable power of attorney

☐ Do not place on life support ☐ Living will

Exercise
Type Exercise_____

Frequency ☐ 2-3 times/week ☐ 3-4 times/week

☐ daily ☐ occasional ☐ Never

Tobacco
Exposure to second-hand smoke? ☐ Yes ☐ No

Caffeine
☐ Yes ☐ No Types_____

Drug use/ abuse
☐ Never ☐ Quit: Date:_____

☐ Current Type_____

Frequency_____

Route_____

Alcohol
☐ Never ☐ Quit: Date:_____

☐ Current

☐ Daily ☐ Frequently ☐ Occasional ☐ Rarely

☐ Social

Personal

Race_____

Ethnicity_____

Residence ☐Assisting Living ☐Alone ☐Nursing Home

☐ With Family Member ☐ With Spouse

Primary Language _____

Secondary Language_____

Agree to blood transfusion ☐ No ☐ Yes

Recent Travel ☐ No ☐ Yes

Educational/ Employment/ Occupation

Highest level of education_____

Occupation_____

☐ Disabled ☐ Retired

Exposed to work hazards:

☐ Anesthetic agents ☐ Asbestos ☐ Benzene

☐ CRT ☐ Repetitive Hand Motion ☐ Solvents

☐ TB ☐ Toxic Chemicals ☐ Toxin Fumes

History of Present Illness (Check all that apply to your visit today.)

Member	Age		Medical Conditions (Please check all that apply and circle cause of death.)
Mother		☐Living ☐Deceased	☐Irregular Heart Rhythm ☐Enlarged Heart ☐Congestive Heart Failure ☐Stroke ☐Coronary Artery Disease ☐High Blood Pressure ☐Heart Attack ☐Sudden Death ☐Valvular Heart Disease ☐Diabetes ☐Other_____
Father		☐Living ☐Deceased	☐Irregular Heart Rhythm ☐Enlarged Heart ☐Congestive Heart Failure ☐Stroke ☐Coronary Artery Disease ☐High Blood Pressure ☐Heart Attack ☐Sudden Death ☐Valvular Heart Disease ☐Diabetes ☐Other_____
Sister		☐Living ☐Deceased	☐Irregular Heart Rhythm ☐Enlarged Heart ☐Congestive Heart Failure ☐Stroke ☐Coronary Artery Disease ☐High Blood Pressure ☐Heart Attack ☐Sudden Death ☐Valvular Heart Disease ☐Diabetes ☐Other_____
Brother		☐Living ☐Deceased	☐Irregular Heart Rhythm ☐Enlarged Heart ☐Congestive Heart Failure ☐Stroke ☐Coronary Artery Disease ☐High Blood Pressure ☐Heart Attack ☐Sudden Death ☐Valvular Heart Disease ☐Diabetes ☐Other_____
			☐Irregular Heart Rhythm ☐Enlarged Heart ☐Congestive Heart Failure ☐Stroke ☐Coronary Artery Disease ☐High Blood Pressure ☐Heart Attack ☐Sudden Death ☐Valvular Heart Disease ☐Diabetes ☐Other_____

Reviews of Symptoms (Please check all of your **current** symptoms.)	
Cardiac	☐Chest Pain ☐Excessive Sweating ☐Shortness of breath lying flat ☐Palpitations ☐Syncope ☐Shortness of breath that awakens you from your sleep
Vascular	☐Painful, aching, or tired feeling in legs while walking ☐Swelling of ankles and feet
Constitutional	☐Weight Gain ☐Weight Loss ☐Fever
HEENT	☐Visual Changes ☐Hearing Loss
Respiratory	☐Snoring ☐Coughing Blood ☐Shortness of Breath
Gastrointestinal	☐Nausea ☐Heart Burn ☐Rectal Bleeding/ Bloody Stool
Genitourinary	☐Blood in Urine ☐Excessive Nighttime Urination
Neurological	☐Dizziness ☐Memory Loss ☐Seizure
Psychiatric	☐Depression ☐Hallucinations
Hematologic	☐Acute Anemia ☐Thrombocytopenia (low platelet count)
Reproductive	☐Erectile Dysfunction ☐History of Oral Contraception
Endocrine	☐Goiter ☐Tremors
Dermatologic	☐Rash ☐Skin Sores
Musculoskeletal	☐Joint Pain ☐Muscle Pain

Continue to Next Page to Complete Medication List

Name of Pharmacy:____________________________ **Address** (If Known):_____________________________________

City:__________________ **State**:______ **Zip Code**:______________

Pharmacy Phone:_______________________________ **Pharmacy Fax**:____________________________________

Medications (*List all prescription and over-the-counter medications that you are currently taking. Include vitamins, herbal supplements, and medications taken as needed.)***

Medication e.g.: Aspirin	**Dosage** e.g.: 81mg	**Frequency** e.g.: once daily	**Prescribing Doctor** e.g.: Dr. Lewis	**Start Date** If known