CARDIOVASCULAR MEDICINE, P.C.
Patient Medical History

PLEASE COMPLETE THIS FORM BEFORE YOUR APPOINTMENT!!

******Bring all current medications to your appointment including vitamins, herbal medications and any over the counter medications you may be taking. ********

Date of Appointment:_____

Patient Name:_____Date of Birth/Age _____
Allergies: Drugs and reaction:_____
Food (e.g. Seafood, Shellfish) _____
Latex Yes No Iodine/x-ray dye Yes No

Risk Factors:
Tobacco use? Yes Never Quit Year Quit_____
If yes – Type: Cigarettes Cigars Pipe Chewing
How many per day?__ How many years? ___
Street Drugs___Yes___ No_____
Diabetes? Yes___ No___ Year Diagnosed_____
High Cholesterol? Yes ____ No ___ Year Diagnosed_____
Hypertension? Yes __ No__ Year Diagnosed _____
Family History of Coronary disease before 60 yrs of age Yes _____ No _____

Mark if you have ever had or currently have the following and the year.

Blood Clots_____ Heart Attack_____
Sleep Disorder/Apnea_____ Stroke/TIA'S_____
Tuberculosis_____ Chest Pain_____
Lung Disease _____ Rheumatic Fever_____
Asthma _____Thyroid disease_____
Heart Murmurs_____Peripheral Vascular Disease _____
Kidney Disease_____ Blood Transfusions _____
Cancer _____Hepatitis _____
Other_____
_____

Operations (Surgeries) or Hospitalization with dates
_____
_____
_____

Family Cardiac History: (cardiac/vascular history such as: Heart attack, bypass surgery, congenital heart problems, sudden death, arrhythmia, congestive heart failure, stroke, stents in legs or heart, pacemaker, Diabetes, etc.)
Father_□ living □ deceased age_____
History _____
Mother □ living □ deceased age_____
History _____
Brothers ages_____
History_____
_____
Sisters ages_____
History _____
_____

Social History
Marital Status_____
Employed Retired Disabled
Occupation _____
Children Sons_____ Daughters _____

Diet Regular Special _____

Alcohol consumption: Yes _____No_____
Amount_____
Exercise: Regular Occasional Sedentary
Active lifestyle Unable

_____

Please list previous cardiac procedures with dates:
(Stress test, EKG, Echocardiogram, Heart Cath, etc.)

_____

_____

_____

_____

PLEASE CHECK ONLY WHAT IS A CURRENT OR LONG STANDING PROBLEM

Central Nervous System	Comments	Skin & Breast	Comments
□ seizures		□ breast lump	
□ light headedness		□ change in color of mole	
□ vertigo (spinning)		□ sores that won't heal	
□ decreased alertness		□ numbness and tingling	
□ migraine headaches		□ itchy skin	
□ unilateral weakness		□ rash	
□ frequent headaches		**Kidney/Bladder**	
□ unsteady walk		□ urinary frequency/burning	
□ tremors/convulsions		□ blood in urine	
□ difficulty with speech		□ prostate problems (males)	
Eye, Ear, Nose & Throat			
□ vision problems			
□ hearing loss		**Musculoskeletal**	
□ ringing in ears		□ joint pain/swelling	
□ sinus problems		□ swelling of feet/ankles	
□ frequent colds		□ joint stiffness	
□ unilateral loss of vision		□ muscle weakness	
□ difficulty swallowing		□ pain in legs when walking	
Stomach/Intestine			
□ heartburn		**Respiratory (lungs)**	
□ indigestion		□ cough	
□ diarrhea		□ shortness of breath lying down	
□ diarrhea after meals		□ coughing up blood	
□ blood in stools		□ wheezing	
□ abdominal discomfort		□ shortness of breath at night	
Blood/Lymph Glands		□ shortness of breath	
□ abnormal bruising			
□ abnormal bleeding		**Psychiatric**	
□ swollen glands		□ anxiety	
		□ depression	
Endocrine		□ mood swings	
□ hotter/colder than others			
□ flushing		**Miscellaneous**	
		□ fever, chills	
Allergies/Immunology		□ unusual wt gain/loss _____ lbs	
□ seasonal allergies		□ unusually tired	
□ frequent infections		□ loss of appetite	

PATIENT SIGNATURE _____ **DATE** _____