CARDIOVASCULAR MEDICINE, PLLC

Patient Medical History

Cardiovascular Medicine, PLLC

Bring all current medications to your appointment including vitamins, herbal medications and any over-the-counter medications

Please complete this form before your appointment

Date of Appointment _____

Patient Name _____ Date of Birth _____ Preferred Pharmacy _____

ADVANCED DIRECTIVES: Durable Power of Attorney (Will): ☐ Yes ☐ No

Healthcare Proxy (Living Will): ☐ Yes ☐ No

ALLERGIES:

Drugs and Reaction:	
Seafood or Shellfish ☐ Yes ☐ No	Iodine/X-Ray Contrast ☐ Yes ☐ No
Latex ☐ Yes ☐ No	

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Children: ☐ Yes, Daughters (#) _____ Sons (#) _____ ☐ No

Employed: ☐ Yes, Occupation _____ ☐ No ☐ Retired ☐ Disabled

Diet ☐ Regular ☐ Special _____

Exercise ☐ Sedentary ☐ Moderate ☐ Vigorous

Tobacco Use ☐ Never ☐ Yes, please continue filling out next section:

- Tobacco Products Used ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing ☐ Vaping

How many per day _____ Number of Years Used _____

Age Started _____ Age Stopped_____

Year Quit _____

Alcohol Consumption ☐ Yes ☐ No If yes, type and amount _____

Street Drug Use ☐ Yes ☐ No

Caffeine Consumption ☐ Yes ☐ No If yes, type and amount _____

FAMILY CARDIAC HISTORY: *Please include cardiac/vascular history; heart attack, congenital heart problems, sudden death, arrhythmia, congestive heart failure, stroke, stents in legs or heart, pacemaker etc.*

Family history of Coronary Disease before 60 years old? ☐ Yes ☐ No

Member		Living	Deceased	Age	History	Cause of Death
Father						
Mother						
Brother (s)						
Sister (s)						

PAST MEDICAL HISTORY:

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

	√	Year		√	Year
Diabetes			High Cholesterol		
Blood Clots			Hypertension		
Sleep Disorder			Heart Attack		
Tuberculosis			Stroke/TIA's		
Lung Disease			Rheumatic Fever		
Asthma			Thyroid Disease		
Heart Murmurs			Peripheral Vascular Disease		
Kidney Disease			Blood Transfusions		
Cancer			Hepatitis		
Other:					

SURGICAL HISTORY:

Surgeries	Year

CARDIAC HISTORY:

Please list previous cardiac procedures (Stress test, Echocardiogram, Heart Catheterization, etc.)

1)._____Year:_____

2)._____Year:_____

3)._____Year:_____

4)._____Year:_____

5)._____Year:_____

REVIEW OF SYSTEMS:

PLEASE CHECK ONLY WHAT IS A CURRENT OR ONGOING PROBLEM

	√		√		√
Weight Gain		Weight Loss		Fever	
Visual Changes		Hearing Loss			
Snoring		Coughing Up Blood		Short of Breath	
Nausea		Reflux		Bleeding	
Hematuria (Blood in Urine)		Night Time Urination			
Dizziness		Memory Loss		Seizures	
Depression		Hallucinations		Anxiety	
Acute Anemia		Low Platelets			
Female-History of Oral Contraceptives		Male-Erectile Dysfunction			
Goiter		Tremors			
Rash		Skin Sores			
Joint Pain		Muscle Aches			

PATIENT SIGNATURE _____ ***D ATE*** _____