

PATIENT PERSONAL HISTORY

Name:	Date:
Age:	Referring Physician:
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Self - referred <input type="checkbox"/> Primary physician:

What is your reason for seeing the doctor today?

PAST MEDICAL HISTORY:

Please check all that apply. Please note date of procedure when applicable.

	Patient	Father	Mother	Siblings	Children
Heart attack					
Blocked artery (heart)					
Heart catheterization					
Balloon angioplasty					
Stent insertion					
High cholesterol					
High blood pressure					
Diabetes					
Coronary bypass surgery					
Heart valve surgery					
Congestive heart failure					
Pacemaker					
Pacemaker/defibrillator					
Tachycardia (heart racing)					
Atrial fibrillation/flutter					
Ventricular arrhythmia					
Ablation procedure					
Stroke					
Carotid artery disease					
Carotid endarterectomy					
Abdominal aortic aneurysm					
Thoracic aortic aneurysm					
Cerebral aneurysm (head)					
Surgical repair of aneurysm					



	Patient	Father	Mother	Sibling	Children
Repair of aneurysm - stent					
Peripheral arterial disease (blocked arteries in legs)					
Balloon or stent to legs					
Balloon or stent to kidney					
Heart murmur as a child					
Heart murmur as an adult					
Congenital heart disease					

List any medications you are currently taking:

Please list any drug or food allergies you may have: _____

Past surgeries/dates:

Do you now have or in the past 6 months experienced:

- Chest pain Explain: _____
- Shortness of breath _____ with exertion _____ at rest
- Wake from sleep because of shortness of breath
- Sleep with elevated head to facilitate breathing
- Palpitations, heart racing or skipping beats
- Pain or swelling in your legs
- Headaches
- Dizziness



- Visual problems
- Passing out
- Ringing in your ears

Please check all that apply:

- Smoking Amount: _____ How long: _____
- Smokeless tobacco
- Alcohol Amount: _____ How often: _____
- Coffee, tea, or other caffeinated beverages # per day: _____
- Recreational drugs

What is your occupation? _____

How many hours per week do you work? _____

Marital status: ___ Married ___ Single ___ Widow ___ Divorced ___ Separated

What other concerns do you have today?

