Heart & Vascular Institute

PAST MEDICAL HISTORY

Patient Name:_____Patient DOB_____
Referring Physician:_____

CARDIAC HISTORY

If checked, when,

- □ Heart Attack _____
- □ Bypass Surgery _____
- □ Angioplasty / Stent _____
- □ Treadmill _____
- □ Echocardiogram _____
  (Cardiac Ultrasound)
- □ Irregular Heart Rhythm_____
- □ Congenital Heart Disease_____
- □ Heart Murmur _____
- □ Pacemaker _____
- □ Rheumatic Fever _____
- □ Stroke / TIA _____
- □ Congestive Heart Failure _____

RISK FACTORS

When Onset:

- □ Hypertension _____
- □ Diabetes _____
- □ Elevated Cholesterol_____
- □ Kidney Disease _____
- □ Thyroid Disease _____
- □ Cancer _____
- □ Anemia _____
- □ Bleeding Problems _____
- □ Eye Problems _____
- □ Weight Loss _____
- □ Head / Nose / Mouth: _____
- □ Lungs: _____
- □ Gastrointestinal: _____
- □ Skin: _____
- □ Neurological: _____
- □ Psychological: _____
- □ Musculoskeletal: _____
- □ Stress _____

REVIEW OF SYSTEMS

(Check All That You Have Been Treated For)

- □ Chest Pain If checked, when: _____
- □ Shortness of Breath If checked, when: _____
- □ Ankle Swelling If checked, when: _____
- □ Dizziness If checked, when: _____
- □ Fainting If checked, when: _____
- □ Other: _____ If checked,

SOCIAL HISTORY

Occupation:_____
Do you use tobacco? □ Past (Quit: _____) □ Present □ Never
Packs per day? ____ Cans per day? _____
Exposed to second hand smoke at home? □ Past □ Present □ Never
Do you use alcohol? □ Past (Quit: ____)
□ Present □ Never How many drinks per day? _____
Do you exercise? □ Yes (Type: _____ Frequency: _____) □ No
Consume caffeine, tea, soda? □ Past
□ Present □ Never How many drinks per day? _____
Dietary Pattern: □ Unrestricted □ Low Fat / Cholesterol □ Low Salt
□ Other: _____

SURGERIES / HOSPITALIZATIONS

Date / Location — Physician Comments

① _____
② _____
③ _____
④ _____

FAMILY HISTORY

Relation	Alive	Significant Health Problems (Mark All That Apply)	
Father	Y / N	□ Heart Attack/Heart Disease (Age at Onset: ____)	□ Heart Surgery (Age at Onset: ____)
		□ High Cholesterol (Age at Onset: ____)	□ High Blood Pressure (Age at Onset: ____)
		□ Stroke (Age at Onset: ____)	□ Heart Failure (Age at Onset: ____)
Mother	Y / N	□ Heart Attack/Heart Disease (Age at Onset: ____)	□ Heart Surgery (Age at Onset: ____)
		□ High Cholesterol (Age at Onset: ____)	□ High Blood Pressure (Age at Onset: ____)
		□ Stroke (Age at Onset: ____)	□ Heart Failure (Age at Onset: ____)
Sibling Gender: F / M	Y / N	□ Heart Attack/Heart Disease (Age at Onset: ____)	□ Heart Surgery (Age at Onset: ____)
		□ High Cholesterol (Age at Onset: ____)	□ High Blood Pressure (Age at Onset: ____)
		□ Stroke (Age at Onset: ____)	□ Heart Failure (Age at Onset: ____)
Sibling Gender: F / M	Y / N	□ Heart Attack/Heart Disease (Age at Onset: ____)	□ Heart Surgery (Age at Onset: ____)
		□ High Cholesterol (Age at Onset: ____)	□ High Blood Pressure (Age at Onset: ____)
		□ Stroke (Age at Onset: ____)	□ Heart Failure (Age at Onset: ____)
Child Gender: F / M	Y / N	□ Heart Attack/Heart Disease (Age at Onset: ____)	□ Heart Surgery (Age at Onset: ____)
		□ High Cholesterol (Age at Onset: ____)	□ High Blood Pressure (Age at Onset: ____)
		□ Stroke (Age at Onset: ____)	□ Heart Failure (Age at Onset: ____)
Child Gender: F / M	Y / N	□ Heart Attack/Heart Disease (Age at Onset: ____)	□ Heart Surgery (Age at Onset: ____)
		□ High Cholesterol (Age at Onset: ____)	□ High Blood Pressure (Age at Onset: ____)
		□ Stroke (Age at Onset: ____)	□ Heart Failure (Age at Onset: ____)

I certify that all the information is correct to the best of my knowledge. I will not hold my doctor or any staff members responsible for any errors or omissions I may have made in the completion of this form.

Patient Signature: _____

Date: _____