Hopkins Cardiovascular Associates

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____ Date of Birth _____

Past Medical History:

Have you ever had or been treated for the following:

- o Rheumatic Fever
- o Heart Murmur
- o High Cholesterol
- o High Blood Pressure
- o Congestive Heart Failure Date and Place of Admission _____
- o Diabetes Number of years ____ Most recent Hg A1c ____
- o Heart Attack Dates _____
- o Other Medical Problems or Diagnoses _____
  _____
- o Previous Noncardiac Surgeries (with date) _____
  _____
- o Atrial Fibrillation or Flutter
- o Irregular Heart Beat
- o Peripheral Vascular Disease
- o Abnormal ECG

Have you ever had the following tests performed:

- o Heart Catheterization Dates _____ Hospital _____
- o Angioplasty or Stents Date, Location, Details _____
- o Heart or Vascular Surgeries Date, Location, Details _____
- o Stress Test Date _____
- o Echocardiogram Date _____

Allergies _____ o No known allergies

Tobacco ____ Type(s) _____ Amount per Day _____ For ___ Years Date Stopped _____

Alcohol Consumption o Never o Occasional o Daily o Excessive

Exercise: _____ times per week for ____ minutes. Examples _____

Family History:

Mother Living _____ Age & Cause of Death _____ History of Heart or Vascular Disease _____

Father Living _____ Age & Cause of Death _____ History of Heart or Vascular Disease _____

# of Siblings ____ # Alive ____ Cause(s) of Death _____ Heart/Vascular Disease _____

Any particular symptoms or concerns _____

_____

_____