



MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Please check which of the following conditions you personally have been diagnosed with or any symptoms you currently have

<u>Cardiac/Vascular</u>		<u>General</u>	
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hypotension (low blood pressure)	<input type="checkbox"/> Hypertension (high blood pressure)
<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Amaurosis Fugax	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Aortic Stenosis	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Erectile Dysfunction
<input type="checkbox"/> Embolism	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Asthma	<input type="checkbox"/> Migraines
<input type="checkbox"/> Heart Attack (when)	<input type="checkbox"/> Pericardial Effusion	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hepatitis -Type
<input type="checkbox"/> Pericarditis	<input type="checkbox"/> Rheumatic Heart Disease	<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Pain in Leg/Arm
<input type="checkbox"/> Sinus Arrhythmia	<input type="checkbox"/> Atrial Fibrillation (A-fib)	<input type="checkbox"/> Cancer – Type	<input type="checkbox"/> Pleural Effusion
<input type="checkbox"/> Atrial Flutter (A-flutter)	<input type="checkbox"/> PVCs	<input type="checkbox"/> COPD	<input type="checkbox"/> Lymphedema
<input type="checkbox"/> Extra or skipped beats	<input type="checkbox"/> Valvular heart Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Menopause
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity
<input type="checkbox"/> Carotid Artery Disease (Neck Arteries)	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> TIA (mini Stroke)	<input type="checkbox"/> Weak Pulses in your feet or wrists	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> DVT – (Blood Clot in Arm or Leg)	<input type="checkbox"/> PVD/PAD (blockages in your veins or arteries)	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Kidney
<input type="checkbox"/> Raynaud's Disease	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Seizure	<input type="checkbox"/> Snoring
<input type="checkbox"/> Renal Artery Stenosis (blockage in kidney arteries)	<input type="checkbox"/> Renal Artery Stenosis	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Sleep Apnea/ CPAP
<input type="checkbox"/> Subclavian Stenosis	<input type="checkbox"/> Thoracic Outlet Syndrome	<input type="checkbox"/> GERD/ Heartburn	<input type="checkbox"/> Visual
<input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> Venous Insufficiency	<input type="checkbox"/> GI Bleed	<input type="checkbox"/> Fatigue
		<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> HIV



MEDICAL HISTORY CONT.

Patient Name _____ Date of Birth _____

SOCIAL HISTORY

Alcohol Use: Yes No Previous

If yes, How Often? _____

How Much? _____

How Long?

Recreational Drug Use: Yes No Previous

If yes, Type of drug _____

Frequency _____

Last Use _____

Tobacco Use: Yes No Previous

If yes, Number of packs per day _____

Are you Interested in Quitting? _____

FAMILY HISTORY (LIST WHO)

___ Abdominal Aortic Aneurysm

___ Bleeding Problems

___ Coronary Artery Disease (Heart Attack, Stent, Bypass Surgery)

___ Heart Failure

___ Diabetes

___ Pulmonary (lung) disease

___ Sudden Cardiac Death

___ Stroke

___ Peripheral Vascular Disease

___ Cancer

SURGICAL HISTORY

Check the appropriate box(es) if you have had any of the following procedures in the past.

- ___ **NO** Prior or no prior significant surgeries
- ___ Serious or Advanced reaction to anesthesia
- ___ Easy Bruising Tendency
- ___ Easy Bleeding

FEMALES

- ___ Breast Surgery
- ___ Hysterectomy
- ___ Tubal Ligation
- ___ Cesarean Section

MALES

- ___ Prostate Surgery

GENERAL

- ___ Appendectomy
- ___ Gallbladder Surgery
- ___ Bladder Surgery
- ___ Lithotripsy
- ___ Colectomy
- ___ Back Surgery
- ___ Hip Replacement
- ___ Hernia Repair
- ___ Amputation
- ___ Ileostomy
- ___ Lung Surgery
- ___ Tonsil/Adenoids
- ___ Knee Replacement
- ___ Shoulder Surgery
- ___ Small Bowel Resection



CARDIOVASCULAR

Please list the Hospital and Year the procedure was performed if known and any other pertinent details.

___ Cardiac Catheterization ("Heart Cath") / Coronary Angiogram - _____

___ Coronary Stent (Stent placed in a blocked artery of heart) / PTCA - _____

___ CABG (Heart Bypass Surgery) - _____

___ Heart Valve Repair / Replacement - _____

___ Pacemaker - _____

___ Defibrillator (shock box) _____

___ Abdominal Aortic Aneurysm STENT or Repair _____

___ Thoracic Aortic Aneurysm STENT or Repair _____

___ Blood Vessel Repair _____

___ Popliteal aneurysm _____

___ Iliac artery aneurysm _____

___ Carotid Stent (neck artery) _____

___ Carotid Endarterectomy _____

___ Renal (Kidney) Angiogram _____

___ Renal (Kidney) angioplasty and/or stent to kidney artery _____

___ Leg Angiogram or leg stent placement _____

___ Leg Bypass _____

___ Angiography other location (Specify) _____

___ Vein Stripping (Location - please specify) - _____

___ Vein Ablation (Location - please specify) - _____

___ Other Procedures to the Heart, Arteries or Veins _____

Signature of Patient _____ Date _____