PARTO HEART & VASCULAR

# MEDICAL HISTORY FORM

**Patient Name:** _____ **Date:** _____ ☐ **New** ☐ **Established**

**Birthday:** _____ **Age:** _____ **Primary Care or Referring MD:** _____

**Pharmacy/Address/City/State/Zip:** _____ **Phone #:** _____

**Reason for today's visit**: _____

---

**Are you now or have you ever been treated for any of the following? (Check all that apply)**

| | | | | |
|---|---|---|---|---|
| ☐ Chest Pain | ☐ Heart Attack | ☐ High Blood Pressure | ☐ High Cholesterol | ☐ Diabetes |
| ☐ Stroke | ☐ COPD | ☐ Carotid Disease | ☐ Heart Failure | ☐ Heart Valve Problem |
| ☐ Heart Murmur | ☐ Rheumatic Fever | ☐ Heart Rhythm Problem | ☐ Vascular Disease | ☐ Asthma |
| ☐ Tuberculosis | ☐ Anemia | ☐ Blood Disorder or Clots | ☐ Stomach Ulcer | ☐ Heartburn/Reflux |
| ☐ Thyroid Problem | ☐ Kidney Disease | ☐ Gallbladder | ☐ Hepatitis | |
| ☐ Sleep Apnea | ☐ Arthritis | ☐ Seizures | ☐ Cancer | |

**Please list surgeries (include location and date):** _____

_____

**Have you received the annual flu vaccination?** ☐**Yes** ☐**No** **Pneumonia vaccination within the last 5 yrs?** ☐**Yes** ☐**No**

**Are you currently experiencing any of the following? (Check all that apply)**

| | | | | |
|---|---|---|---|---|
| ☐ fatigue | ☐ weight gain | ☐ vertigo | ☐ ringing in ear | ☐ cold/heat intolerance |
| ☐ dizziness | ☐ weight loss | ☐ abdominal pain | ☐ indigestion | ☐ pain in legs/buttocks at rest |
| ☐ passing out | ☐ swelling | ☐ excessive snoring | ☐ nausea | ☐ pain in legs/buttocks when walking |
| ☐ palpitations | ☐ easy bruising | ☐ blood in urine | ☐ cough | ☐ Excessive thirst/urination |
| ☐ chills | ☐ nose bleeds | ☐ blood in stool | ☐ wheezing | ☐ muscle weakness/pain |
| ☐ fever | ☐ vomiting blood | ☐ vision changes | ☐ shortness of breath | |

**Have you ever had any of the following heart tests? (Include location and date)**

Cardiac Catheterization _____ Stress Test (exercise test): _____

Echocardiogram: _____ Stress Echocardiogram: _____

Nuclear Stress Test: _____

Holter Monitor (24/48 hrs.) or Event Monitor (30 days): _____

**Habits:**

Do you smoke? ☐ Yes ☐No How many years? _____ Packs Daily: _____ Interested in quitting? ☐ Yes ☐No

Did you ever smoke? ☐ Yes ☐No How many years? _____ Packs Daily: _____ When did you quit? _____

How much alcohol do you drink? _____ day _____ week _____ month _____ year

How many caffeinated drinks do you drink? (Coffee, tea, soda) _____day _____week

Are you allergic to any medications? ☐ Yes ☐No, please list: _____

_____

Check all that you are allergic to: ☐ Dye used for X-rays (IV dye) ☐ Adhesive Tape ☐ Latex ☐Shell Fish

| **Family History** | Living | Age | Heart Problem | High Blood Pressure | High Cholesterol | Stroke | Diabetes | Cancer |
|---|---|---|---|---|---|---|---|---|
| Father | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brother(s) | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sister(s) | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Paternal Grandpa | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Paternal Grandma | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Maternal Grandpa | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Maternal Grandma | ☐ Y ☐N | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Medications:

### Include vitamins, herbal supplements, and over the counter mediations

| Name | Dose | How many times a day? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |