CARDIOVASCULAR HISTORY

DATI	Ξ:	_
NAM	E:	
AGE:		
SEX:		_
1.	CHIEF COMPLAINT: (What is the major office? Date of onset?)	or symptom or problem that brought you to the

2.	When did symptoms first start?
3.	Where does the pain/symptoms start?
4.	How long did the 1 st episode last?
5.	On a scale of 1 to 10 (with 10 being the worst), what level would you say your pain/symptom is?
6.	Does the pain spread around or travel straight through?
7.	How long does symptom last?
8.	What is the timing of the symptom? (Ex. Sudden onset, gradual onset, night, morning, upon wakening,
	during day, while sleeping, stress, etc.)
9.	Does anything in particular bring the symptom on? (Ex: exercise, emotions, eating, sleep, sex, etc.)
10.	Aggravating factors:
11.	What gives relief?
12.	When the symptom occurs, are there any other symptoms at the same time? (Ex: nausea, vomiting,
	shortness of breath, palpitations, faintness, numbness, etc?)
13.	Have you ever seen a Cardiologist before?
	If so, what was the Cardiologist's name and address?
14.	Have you ever been diagnosed with a heart condition at ANY time in the past?
15.	Do you have pain in legs when walking?

PAST MEDICAL HISTORY

(Please list any problems you may have had in the past) **HEENT:** (Head, eyes, ears, nose, throat) RESPIRATORY: (Chronic Lung disease, pneumonia, etc.) HEART: a. Stroke _____ c. Thrombophlebitis _____ b. Heart murmur _____ d. Congestive Heart Failure ____ BONE & JOINT: _____ SKIN: _____ NEUROLOGICAL: PSYCHIATRY: ____ ENDOCRINE: VASCULAR: GASTROINTESTINAL: GENITOURINARY: **HEMATOLOGY:** (Anemia, blood disorders, etc.) Have you ever been diagnosed as having **HIGH CHOLESTEROL?** Have you ever been diagnosed as having **DIABETES?** Have you ever been diagnosed as having **HYPERTENSION?** Have you ever been diagnosed as having **RHEUMATIC FEVER?**

Do you have any known	DRUG ALLERGIES	S?	_ Yes	No
If yes, please list drug na	me and the type of rea	ection it causes:		
	DACT	IIDCICAI U	TCTADV	
	PASI S	URGICAL H	151UK1	
			L & SURG	EON who performed surgery,
including ANY PRIOR	HEART SURGERY)		
m		**		
Type of Sur	gery	Hospital/Doc	etor	Date
			T	

Patient Name:	DOB:	
Patient Name:	DOB:	

FAMILY HISTORY

Please fill in each category (Age, Living/Deceased) of mother, father, brothers, sisters, etc.

IF LIVING

IF DECEASED

	Se	X	Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

Stroke	Epilepsy	Heart Attack	Nervous Breakdown
Cancer	Suicide	Stomach Ulcers	Rheumatic Fever
High Blood Pressure	Migraine	Kidney Disease	Insanity
Diabetes	Asthma	Goiter	Congenital Heart
Leukemia			
	Hayfever	Arthritis	
Tuberculosis	Bleeding Tendency	Colitis	

Do you know of any blood relative who has or had: (Circle and give relationship)

CURRENT MEDICATIONS

(Please list ALL medicines currently taking: aspirin, vitamins, over-the-counter, herbal, etc.)

Name of Drug	Strength	Instructions	Prescribing Physician

SOCIAL HISTORY

1.	Do you Smoke? _	YesNo	Packs per day	No. of Years		
	Discontinued smo	okingYes	No How Long	Ago?		
2.	Alcohol Intake?	Never	Occasionally	Socially		
	-	Beer	Wine	Other		
	How often?	Daily	Weekly	Monthly		
3.	Diet: No Partic	ular diet	Low Fat/L	ow Cholesterol		
	Moderate	Fatty Diet	High fatty	diet Diabetic Di	et	
4.	Lifestyle:	M	arriedWid	owedDivorced _	Other	
5.	Exercise: (walking	, running, weights, v	vorking out in gym. etc	c.)		
	, ,					
	Frequency	How many tin	ies a week	How many times a month		
6.	6. Average amount of Sleep per night: (hours)					
7.	Education: High	School Education_	College	Degree		
	C		υ —	_ 5 _		
8.	Occupation:					
9.	Spouse's Occupat	zion:				