ADVANCED CARDIOVASCULAR CENTER

Patient Medical History Form

First Name:..... M.I.: ..... Last Name:.....

Date of Birth:..... Phone:..... Email:.....

Reason for Visit:.....

Referring Physician:..... PreferredHospital:.....

Social History:

Smoker (cigarettes): ☐ Yes ☐ No ☐ Quit How many packs per day?.....

Alcohol Use: ☐ Yes ☐ No ☐ Socially how many drinks per day? .....

Illicit Drug Use: ☐ Yes ☐ No ☐ What type/how often? .....

Exercise: ☐ Yes ☐ No ☐ How often.....per week?

Type of exercise: .....

Personal History

Marital Status: .....Occupation: .....

Family History:

Has the patient's family had any of the following medical conditions?

☐ Bleeding Disorders ☐ Diabetes Mellitus ☐ Family History Is Unknown

☐ Clotting Disorders ☐ Thyroid Disorder ☐ Patient is Adopted

Cardiac Family History:

Has the patient's family had any of the following cardiac conditions?

Coronary Artery Disease:	☐ Parent	☐ Sibling	☐ Child	☐ Other
Age of Onset:	.....	.....	.....	.....
Congestive Heart Failure:	☐ Parent	☐ Sibling	☐ Child	☐ Other
Age of Onset:	.....	.....	.....	.....
High Cholesterol:	☐ Parent	☐ Sibling	☐ Child	☐ Other
Age of Onset:	.....	.....	.....	.....
High Blood Pressure:	☐ Parent	☐ Sibling	☐ Child	☐ Other
Age of Onset:	.....	.....	.....	.....
Stroke:	☐ Parent	☐ Sibling	☐ Child	☐ Other
Age of Onset:	.....	.....	.....	.....

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Personal Medical History: Has the patient had any of the following medical conditions?

Cardiac Risk Factors:

☐ High cholesterol/triglycerides ☐ High blood pressure (hypertension) ☐ Diabetes Mellitus

Heart History:

☐ Heart Attack ☐ Atrial Fibrillation ☐ Arrhythmia (Irregular beats) ☐ Congestive Heart Failure

☐ Heart Murmur ☐ Valvular Disease ☐ Peripheral vascular disease ☐ Pericarditis

☐ Thromboembolic Disease (hx of clots) ☐ Mitral valve prolapse ☐ Coronary Artery Disease (blocked arteries)

Vein History:

☐ Varicose Veins ☐ Edema (Swelling)** ☐ Venous Reflux ☐ Throbbing legs

Neurological History:

☐ Stoke ☐ Fainting ☐ Neuropathy ☐ Migraine Headache ☐ Transient Ischemic Attack

Endocrine History:

☐ Hyperthyroidism ☐ Hypothyroidism ☐ Obesity

Gastroenterology History:

☐ Blood in the stool ☐ GERD ☐ Hepatitis ☐ Peptic ulcer

Other History:

☐ Bleeding Disorder ☐ Intravenous drug use ☐ Rheumatic fever

☐ Cancer ☐ Renal/Kidney failure ☐ HIV Infection

Other:.....

Non-Cardiac Procedure/Surgery History: Please list past surgeries and include the approximate date.

Surgery	Date (if known)

☐ **Cardiac Tests/Surgery History:** Please check to indicate if the patient has had any of the following.

Cardiac Test/Surgery	Date (if known)	Physician
☐ EKG		
☐ Treadmill Stress Test		
☐ Nuclear Stress Test		
☐ Echocardiogram		
☐ Carotid Ultrasound		
☐ ABI Testing		
☐ Venous Ultrasound		
☐ Cardiac Catheterization		
☐ Coronary Stent		
☐ ICD/Defibrillator/Pacemaker		
☐ Arrhythmia Ablation		
☐ Coronary Artery Bypass		
☐ Cardiac Valve Surgery		
☐ Peripheral Vascular Intervention		
☐ Peripheral Vascular Surgery		

Current Medications: Please list all current medications you are taking, including dosage and frequency.

Preferred Pharmacy:.....**Preferred Pharmacy Phone:**.....

Medication Name	Dosage	Frequency

Allergies: Please check the box if you have ever had an allergic reaction to any of the following:

☐ Intravenous dye ☐ Shellfish ☐ Iodine

Other allergic reactions:

Allergic to:..... Reaction:.....

Allergic to:..... Reaction:.....

Allergic to:..... Reaction:.....

Allergic to:..... Reaction:.....