Patient History

The Heart and Vascular Specialists

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Patient
Name_____DOB_____DATE_____

Do you smoke? □YES □NO If so, how much per week? _____
If you quit, how long ago? _____
Do you drink? □YES □ NO If so, how much per week? _____

Have you ever been diagnosed with any of the following?

High Blood Pressure	□	Shortness of breath	□
High Cholesterol	□	COPD	□
Abnormal EKG	□	Atrial Fibrillation	□
Chest Pain/Angina	□	Sick Sinus Rhythm	□
Palpitations	□	Pacemaker/ICD (Defibrillator)	□
Coronary Artery Disease	□	Peripheral Vascular Disease	□
Coronary Artery Bypass	□	Deep Vein Thrombosis	□
Stents	□	Dizzy Spells	□
Heart Attack	□	Syncope	□
Stroke	□	Diabetes	□
Congestive Heart Failure	□	GERD	□
Leg Pains	□	Tuberculosis (TB)	□
		HIV/AIDS	□

SURGICAL HISTORY:
Did you have Pacemaker/ICD _____
Stents_____
Open Heart/Bypass/Cabbage_____
If you have Pacemaker, ICD or stents please allow the secretary to copy your card.

FAMILY HISTORY: (Father, Mother, Brother, Sister, or child)

Hypertension	□	Hypercholesterolemia	□
Coronary Artery Disease	□	Diabetes	□
Heart Attack	□	Cancer	□

Father's DOB_____ Deceased? □ YES □ NO
Mother's DOB_____ Deceased? □YES □ NO

PRIMARY CARE PHYSICIAN NAME/NUMBER_____
PHARMACY NAME/LOCATION_____