

Patient History

The Heart and Vascular Specialists

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Patient Name _____ 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 | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |
| High Cholesterol | <input type="checkbox"/> | COPD | <input type="checkbox"/> |
| Abnormal EKG | <input type="checkbox"/> | Atrial Fibrillation | <input type="checkbox"/> |
| Chest Pain/ Angina | <input type="checkbox"/> | Sick Sinus Rhythm | <input type="checkbox"/> |
| Palpitations | <input type="checkbox"/> | Pacemaker/ICD (Defibrillator) | <input type="checkbox"/> |
| Coronary Artery Disease | <input type="checkbox"/> | Peripheral Vascular Disease | <input type="checkbox"/> |
| Coronary Artery Bypass | <input type="checkbox"/> | Deep Vein Thrombosis | <input type="checkbox"/> |
| Stents | <input type="checkbox"/> | Dizzy Spells | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | Syncope | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Congestive Heart Failure | <input type="checkbox"/> | GERD | <input type="checkbox"/> |
| | | Leg Pains | <input type="checkbox"/> |

Other _____

If you have a pacemaker, ICD, or stents, please allow the secretary to copy your card.

Family History: (Mother, Father, Brother, Sister, or Child)

- | | | | |
|-------------------------|--------------------------|---------------------|--------------------------|
| Hypertension | <input type="checkbox"/> | Hypercholesterolsis | <input type="checkbox"/> |
| Coronary Artery Disease | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |

Mother's DOB _____

Deceased? Yes No

Father's DOB _____

Deceased? Yes No

Primary Care Physician _____

Pharmacy & Location _____