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	☐	Shortness of Breath	☐
High Cholesterol	☐	COPD	☐
Abnormal EKG	☐	Atrial Fibrillation	☐
Chest Pain/ Angina	☐	Sick Sinus Rhythum	☐
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	☐

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	☐	Hypercholestorolsis	☐
Coronary Artery Disease	☐	Diabetes	☐
Heart Attack	☐	Cancer	☐

Mother's DOB _____ Deceased? ☐ Yes ☐ No
Father's DOB _____ Deceased? ☐ Yes ☐ No

Primary Care Physician _____

Pharmacy & Location _____