

PATIENT HISTORY

Date: _____

Patient Name _____

Age: _____ Weight: _____ Height: _____ Handed (circle one) Right/ Left

Allergies: _____

Are you allergic to iodine? Yes No

Social History:

Caffeine (circle one) Yes/ No. Type: _____ Cups per day: _____

Smoking (circle one) Yes/ No. _____ Packs day _____ Years _____ Years Quit

Alcohol (circle one) Social, Occasional, Never _____ Drinks per week

Illegal Substance Use: _____

Past Medical History: (Circle all that apply)

Ablation Asthma Anemia Aneurysm Angina Arrhythmia Atrial Fibrillation

Bleeding Disorder Cancer (Type: _____) Chest Pain Cardiomyopathy

Coronary Artery Disease Diabetes (medication/ insulin/ both) DVT (blood clot)

Emphysema Heart Murmur Hypertension (high blood pressure)

Hypotension (low blood pressure) Hyperthyroid Hypothyroid High Cholesterol

Myocardial Infraction (heart attack) TIA Pulmonary Embolism Pericarditis Renal

Failure Syncope(pass out) Stroke Valve Disease

Male:

History of Urinary Retention Prostrate Problems Erectile Dysfunction

Female:

Menopause (circle one) Yes No Date of Last Menstrual Period: _____

Birth Control (circle one) Yes No (Name: _____)

Family History:

Mother: (circle one) Living Deceased Age at Death: _____

Her Medical History: _____

Father: (circle one) Living Deceased Age at Death: _____

His Medical History: _____

Siblings: _____

PATIENT HISTORY

Date: _____

Patient Name: _____

Past Surgical History:

<u>Date</u>	<u>Surgery</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pacemaker / ICD Date/ year of implant: _____

Manufacturer: _____

Cardiac Catheterization: Date: _____

Stent Placement: Yes No (drug-eluting or bare metal)

Location: _____

Why are you seeing the Doctor today:

Circle all that apply:

Chest pain Chills Coughing up Blood Belching Blurred Vision

Bruise Easily Decreased Appetite Dizziness Double Vision Fatigue (Tired)

Fever Headaches Hiccups Hypertension (High Blood Pressure)

Known Heart Condition Irregular Heart Beats Insomnia (trouble sleeping)

Palpitations Persistent Cough Nausea/ Vomiting Night Sweats

Shortness of Breath Swelling of Extremities Syncope (passing out)

Weight (loss/gain)

Concerns not Covered in the Medical History Form:
