HEART & VEIN CENTER, P.A.

Name ____________________ Date ____________
Referring Physician ____________________ Primary Care Physician ____________________
DOB ____________ Height ____________ Weight ____________
Have you been treated by our physicians before Yes / No When ____________
When was the last EKG ____________ Last stress test ____________
What pharmacy do you use ____________ Location ____________

Do you have a history of:

Heart Disease Yes / No Murmur Yes / No Chest Pain / Angina Yes / No
Palpitations Yes / No Sleep Apnea Yes / No Shortness of Breath Yes / No
Heart Attack Yes / No When ____________ Where ____________
Heart Cath Yes / No When ____________ Where ____________
Angio / Stent Yes / No When ____________ Where ____________
Bypass Surgery Yes / No When ____________ Where ____________
Pacer / Defib Yes / No When____________ Where ____________

Adult Illnesses:

High Cholestrol Yes / No Stroke / Paralysis Yes / No
High Blood Pressure Yes / No Congestive Heart Disease Yes / No
Cardiomyopathy Yes / No Arthritis Yes / No
Thyroid Disease Yes / No Hepatitis / Jaundice Yes / No
Diabetes Yes / No Cancer Yes / No
Asthma / COPD Yes / No Gallstones / Kidney Stones Yes / No
Depressive Disorder Yes / No Epilepsy / Seizures Yes / No

Surgeries:

Year ________ Reason ____________________ Hospital ____________
Year ________ Reason ____________________ Hospital ____________
Year ________ Reason ____________________ Hospital ____________
Year ________ Reason ____________________ Hospital ____________

Family History:

Father Living ________ Age _______ Heart Disease Yes / No ____________
Deceased ______ Age _______ Cause of Death ____________
Mother Living ________ Age _______ Heart Disease Yes / No ____________
Deceased ______ Age _______ Cause of Death ____________
# of Brothers or Sisters with Heart Disease ____________
Family history of Abdominal Aortic Aneurysm Yes / No

Social History:

Do You Smoke Yes / No How Much ____________ Current Illegal Drug Use ____________
Have You Ever Smoked Yes / No When Did You Quit _____ Past Illegal Drug Use ____________
Do You Drink Alcohol Yes / No How Much ____________ Caffeine Intake ____________

Medications: Name Strength How Often

____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________

Allergies to Medications ____________________