



PATIENT MEDICAL AND FAMILY HISTORY

PATIENT NAME (LAST, FIRST, MI) _____ DATE _____

REASON FOR THIS EVALUATION (What specific questions do you want answered?) _____

DO YOU HAVE ALLERGIES? YES NO IF YES, please list: _____

ALLERGY or IODINE or SHELLFISH? YES NO ALLERGY to IVP DYE? YES NO

PLEASE LIST **ALL** PREVIOUS SURGICAL PROCEDURES: Continue on **BACK** if needed

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Have you **EVER** had any of the following Cardiac Procedures?

- | | | |
|--|--|-------------------|
| STRESS TEST OF ANY KIND | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| ECHOCARDIOGRAM | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| ULTRASOUND OF THE LEGS | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| CAROTID ULTRASOUND | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| RENAL ULTRASOUND | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| CARDIAC CATH | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| PTCA (ANGIOPLASTY) | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| STENTS | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| CORONARY ARTERY BYPASS | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| PACEMAKER IMPLANT | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| DEFIBRILLATOR IMPLANT | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| ABLATION | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| VALVE REPAIR | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| VALVE REPLACEMENT | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |
| If Yes, <input type="checkbox"/> Mechanical <input type="checkbox"/> Pig Valve | <input type="checkbox"/> YES <input type="checkbox"/> NO | Month/Year: _____ |

Have you **EVER** had any of the following?

- | | | | |
|------------|--|---------------|--|
| DIABETES | <input type="checkbox"/> YES <input type="checkbox"/> NO | GOUT | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ANEMIA | <input type="checkbox"/> YES <input type="checkbox"/> NO | ARTHRITIS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| STROKE | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIATAL HERNIA | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CHEST PAIN | <input type="checkbox"/> YES <input type="checkbox"/> NO | ULCER | <input type="checkbox"/> YES <input type="checkbox"/> NO |



PALPITATIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	GALLBLADDER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART MURMUR	<input type="checkbox"/> YES <input type="checkbox"/> NO	THYROID DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
ABNORMAL EKG	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
RHEUMATIC DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	BOWEL DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
BREATHING DIFFICULTY	<input type="checkbox"/> YES <input type="checkbox"/> NO	CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
LIGHTHEADED/DIZZY	<input type="checkbox"/> YES <input type="checkbox"/> NO	SKIN LESIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART ATTACK	<input type="checkbox"/> YES <input type="checkbox"/> NO	PSYCHIATRIC DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HIGH CHOLESTEROL	<input type="checkbox"/> YES <input type="checkbox"/> NO	UNEXPLAINED WEIGHT	<input type="checkbox"/> YES <input type="checkbox"/> NO

Do you currently use or have you previously used TOBACCO? YES NO

If YES, what type? (Please circle one) Cigarette Pipe Cigar Dip/Chew

If CURRENT User: How many years? _____ How many packs/amount per day? _____

If FORMER User: Age Started: ____/Age Stopped: ____ How many packs/amount per day? _____

Do you drink ALCOHOL? YES NO

If YES, how often? (Please circle one) Everyday Occasional Never

Do you drink CAFFEINE? YES NO

If YES, how often? (Please circle one) Everyday Occasional Never

FAMILY HISTORY

Father Living? YES NO Age or Age @ Death: _____ Cause of Death? _____
 Any Illnesses? _____

Mother Living? YES NO Age or Age @ Death: _____ Cause of Death? _____
 Any Illnesses? _____

How many Brothers are living? _____ How many Brothers are deceased? _____
 Any Illnesses? _____ Age/Cause of Death? _____

How many Sisters are living? _____ How many Sisters are deceased? _____
 Any Illnesses? _____ Age/Cause of Death? _____



How many Daughters are living? _____ How many Daughters are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

ACTIVITY HISTORY

What kind of exercise do you do? _____

What is your main hindrance (if any) to exercising? _____

