Patient History Form

Please complete this form to the best of your ability.

Date:	☐ M ☐ F	Date of Birth:
Name:		
Address:		
Phone:	Email:	
Primary Care Physician:		
Cardiologist:		
Previous Vascular Surgeon:		
General Surgeon:		
Nephrologist (kidney doctor):		
Who referred you to our office today?:		
In case of an emergency, whom can we contact?:		
Emergency contact's phone number:		

Why are you being seen today? _____

_____

_____

Briefly list any prior operations or hospitalizations: _____

_____

_____

_____

DO YOU HAVE ANY RISK FACTORS FOR HEART DISEASE?	Yes	No
Hypertension (high blood pressure)		
Diabetes		
High Cholesterol or triglycerides		
Smoking		
History of Rheumatic Fever		
Family history of heart disease before age 60		

WHAT IS YOUR CARDIAC HISTORY?	Yes	No
Heart attack (myocardial infarction)		
Heart surgery (bypass, valve repair or replacement)		
Murmur/valvular heart disease		
Congenital heart disease (at birth)		
Arrhythmia/ Atrial Fibrillation/ Atrial Flutter		
Family history of heart disease before age 60		
Pacemaker or defibrillator		
Syncope (passing out or fainting spells)		

Patient Name: Patient Identification #:

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DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? *(Check all that apply)*

Stroke/TIA		Thyroid problems		Gout	
Blocked carotid arteries		Seizures		Arthritis	
Chronic lung disease		Migraines		Kidney disease	
Asthma		Mental Illness		Cancer	
Pneumonia		Reflux/hiatal hernia		Sleep apnea	
Glaucoma		Stomach ulcers		Gallbladder	
Tooth pain		Blood clots/DVT		Blood infections	
Diabetes		Poor circulation in legs			

WHAT IS YOUR FAMILY HISTORY? (Parents, siblings and your children)

Relation	Age	Age at death *(if applicable)*	Major illnesses or cause of death (*heart disease, stroke, aneurysms, high blood pressure, diabetes, kidney disease, etc) **(if applicable)***
Father			
Mother			
Brother(s)			
Sister(s)			

WHAT IS YOUR SOCIAL HISTORY?

☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated *(check one)*

Children? ☐ Yes ☐ No *If yes,* how many?: _____ Ages?: _____

Who will help you after surgery? _____

Currently employed? ☐ Yes ☐ No

Type of work: _____

Retired? ☐ Yes ☐ No *If yes,* when?: _____

Disabled? ☐ Yes ☐ No *If yes,* when?: _____

Highest level of education: _____

WHAT ARE YOUR HABITS?

Tobacco use? ☐ Yes ☐ No Packs/day:_____ How many years:_____ When did you quit: _____

Alcohol use? ☐ Yes ☐ No How much per week:_____

Recreational drug use? ☐ Yes ☐ No Marijuana? ☐ Yes ☐ No Other drugs?: _____

Caffeine *(coffee, soda, tea, chocolate)*? ☐ Yes ☐ No How much per day: _____

Regular exercise program? ☐ Yes ☐ No

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DO YOU HAVE ANY ALLERGIES?

WHAT ARE YOUR CURRENT MEDICATIONS?

Name	Dose	Frequency
Do you use oxygen?	☐ **Yes**	☐ **No**

Do you take any herbal products or non-prescription medications? *If yes, please list name, dose and frequency:*

Name	Dose	Frequency

DO YOU HAVE ANY OF THE FOLLOWING CARDIAC SYMPTOMS?	Yes	No
Fast or slow heart rate?		
Shortness of breath		
Palpitations or skipped heartbeats		
Chest discomfort or pressure		
Waking up at night due to shortness of breath		
Having to prop up on pillows or sit up at night to breathe		
Swelling in ankles		
Fatigue		

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DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

	Yes	No
Fatigue / inability to do activities of daily living		
Recent weight loss		
Recent weight gain		
Fever		
Vision changes		
Cataracts		
Swelling in ankles		
Fatigue		
Wear eyeglasses		
Trouble with balance		
Hearing loss		
Chest pain		
Irregular heartbeat		
Heart murmur		
Shortness of breath		
Cough		
Pneumonia		
COPD / emphysema / chronic bronchitis		
Abdominal pain		
Diarrhea		
Constipation		
Liver disease		

	Yes	No
Kidney stones		
Painful urination		
Urinary tract infections		
Back pain		
Leg pain		
Arm pain		
Neck pain		
Joint pain or swelling		
Wounds on skin		
Skin cancer		
Stroke		
Difficulty with speech		
Difficulty swallowing		
Seizures		
Diabetes		
Thyroid disease		
Blood clots		
OTHER (describe):		

HAVE YOU HAD ANY OF THE FOLLOWING COMPLETED RECENTLY? *If so, when and where?*

	Yes	No	When / Where
Blood / Lab work			
Cholesterol and triglyceride levels			
Blood sugar			
Stress test			
Echocardiogram (echo, heart ultrasound)			
Heart catheterization			
Holter monitor/event recorder			
Pulmonary function test (lung/breathing test)			
Vein mapping/ankle brachial index (ABI)			
Chest x-ray			
CT scan			
Any other tests or laboratory work (please list):			

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