Heart and Vascular Specialists P.C.

PATIENT'S PERSONAL HISTORY

Patient No.: _____

Please bring your insurance card and medications with you on your appointment date.

Appointment Date: _____

Confidential Record: Information contained here will not be released except when you authorize us to do so.

Last Name	First	Middle	Birth Date	Age

Preferred Pharmacy: _____

Preferred Pharmacy Location: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

Date of Last Examination: _____ Doctor: _____

PCP or Referring Physician: _____ Address: _____

Phone Number: _____ Fax Number: _____

Reason for Today's Visit: _____

PAST MEDICAL HISTORY:

High Blood Pressure N _____ Y _____

Diabetes N _____ Y _____

High Cholesterol N _____ Y _____

Other _____

Other _____

Other _____

Other _____

PAST SURGICAL HISTORY:

Coronary Bypass N _____ Y _____

Heart Valve Surgery N _____ Y _____

Pacemaker/Defibrillatc N _____ Y _____

Stents/Angioplasty N _____ Y _____

Other _____

Other _____

Other _____

Please List Allergies Below:

_____

_____

_____

_____

FAMILY HISTORY:

	Age	Male / Female	Medical Problems	If Deceased... Age at Death	If Deceased... Cause
Father					
Mother					
Brothers / Sisters					
Children					

Do you know of any blood relative who has or had: *(Circle and give relationship)*

Stroke: _____ Cancer: _____ High Blood Pressure: _____

Diabetes: _____ Heart Disease: _____ High Cholesterol: _____

MEDICATIONS (prescription and non-prescription):

We highly recommend that you bring all your pill bottles (including over the counter drugs) to the visit. Otherwise, please list all the medications, strength, and number taken below.

	Medication Name	**Dosage**	**Frequency**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list additional medications on the back page.

Vitamins? N _____ Y _____ Please List _____

Herbs (eg. teas/drinks)? N _____ Y _____ Please List _____

Oral Contraceptives? N _____ Y_____ _____

Occupation: _____ Employer: _____

[ ] Retired [ ] Disabled

Tobacco Use N _____ Y _____ Amount _____ How Long _____ Yr. Stopped: _____

Alcohol Use N _____ Y _____ Type _____ Quantity _____ Frequency _____

Illicit Drug Use N _____ Y _____ Type _____ How Long? _____ Frequency _____

Coffee Use N _____ Y _____ Amount _____ How Long? _____ Frequency _____

Tea Use N _____ Y _____ Amount _____ How Long? _____ Frequency _____

Soft Drinks N _____ Y _____ Amount _____ How Long? _____ Frequency _____

Exercise Regularly? N _____ Y _____ What Kind? _____ How Often? _____

REVIEW OF SYSTEMS:

Have you ***recently*** had any of the following problems? ***(Please check all that apply.)***

Constitutional	Skin	Gastrointestinal	Genitourinary	Ear/Nose/Mouth/ Throat
_____ Fever _____ Chills _____ Headache _____ Major weight change _____ Appetite loss _____ Snoring _____ Stop breathing during sleep _____ Sleep on more than 1 pillow	_____ Rash _____ Itch _____ Ulcers on feet _____ Unexplained hair loss	_____ Abdominal pain _____ Diarrhea _____ Constipation _____ Nausea / Vomiting _____ Heartburn _____ Mucous in the stool _____ Blood in stool _____ Ribbon-like stool	_____ Difficulty urinating _____ Painful urination _____ Frequent urination _____ Blood in urine _____ Urinate more than twice at night _____ Difficulty with erections	_____ Ear infection _____ Sore throat _____ Sinus problems _____ Difficulty swallowing _____ Hoarseness
Cardiovascular	**Respiratory**	**Musculoskeletal**	**Hematologic/ Lymphatic**	**Eyes**
_____ Chest pain _____ High blood pressure [ ] Controlled [ ] Uncontrolled _____ Varicose veins _____ Swelling in ankles/feet	_____ Wheezing _____ Cough _____ Shortness of breath [ ] With Exertion [ ] Without Exertion _____ Asthma _____ Emphysema	_____ Joint pain _____ Neck pain _____ Back pain _____ Leg/hip pain when walking	_____ Swollen glands _____ Blood clotting problems _____ Unexplained bruising	_____ Blurred vision _____ Double vision _____ Eye pain _____ Cataracts _____ Glaucoma

Neurological	Allergic / Immunologic	Psychological	Endocrine
_____ Tremors _____ Dizziness _____ Numbness _____ Arm / leg weakness	_____ Allergies _____ Hay Fever	_____ Depression _____ Anxiety _____ Unusual stress _____ Eating disorder _____ Attempted suicide	_____ Thyroid problems _____ Hot flashes _____ Cold intolerance

Date of last: Pneumovax ___/___/___ Flu Shot ___/___/___ Tetanus ___/___/___ Colonoscopy ___/___/___

Patient's Signature _____ Date_____ Physician Signature _____