



CARDIOVASCULAR
ASSOCIATES, LTD.

NEW PATIENT MEDICAL HISTORY

Patient's Name _____ Date _____

Address _____

Date of Birth _____ Age _____ Marital Status _____

Referring Physician & Address _____

Other physicians you would like to receive a report or letter _____

Reason for referral or visit _____

Is this a second opinion consultation? _____

M E D I C A T I O N S

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.

	Medication	Dosage	Frequency	How long have you been taking this medication?
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

ALLERGIES

LIST ALL DRUG ALLERGIES & YOUR REACTION TO THE MEDICATIONS.

MEDICAL HISTORY

LIST ALL HOSPITALIZATIONS, STARTING WITH THE MOST RECENT AND PROGRESSING BACKWARDS.
INCLUDE ALL HOSPITAL ADMISSIONS, SURGERIES, & PREGNANCIES.

Illness	Date	Procedure	Where

1. Have you ever had a cardiac catheterization ? Yes No
If yes, When _____ Where _____
2. Have you ever had a blood transfusion ?
If yes, When _____ Where _____
3. Have you ever had ulcers ?
If yes, describe _____
4. Do you currently smoke cigarettes? Yes No
How many packs per day? _____ On average? _____ At most? _____
Do you have any serious intention to quit? Yes No
Have you quit smoking? Yes No
If yes, when? _____
How many years did you smoke? _____
Does your spouse smoke? Yes No
5. Do you drink alcohol? Yes No If yes, how much: _____
6. Do you drink beverages containing caffeine? Yes No If yes, how much in a typical day: _____
7. Do you use any _____ (can't read word) drugs? _____
8. FOR FEMALES:
If you have been pregnant, how many times? (include all pregnancies) _____ # of live Births _____
Menopause date of onset _____

F A M I L Y H I S T O R Y

	If Alive, Age	If Alive, State of Health	If Deceased, Cause of Death	Age at Death
Mother				
Father				
Brothers				
Sisters				

S O C I A L H I S T O R Y

1. Are you: Employed Retired Your Occupation _____
 2. Who lives at home with you? _____
 3. Are you married? Yes No
 4. Do you have any hobbies? Yes No If yes, explain _____
 5. How many children do you have? _____
 6. Are you under any unusual stress in your life? Yes No If yes, explain _____
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M E D I C A L C O N D I T I O N S

PLEASE INDICATE ANY OF THE FOLLOWING PROBLEMS THAT YOU HAVE EXPERIENCED.

I. CARDIOVASCULAR

- Chest pain or angina
- Shortness of breath
- Irregular heartbeat
- Fast heartbeat
- Dizziness
- Passing out
- Swelling of feet, ankles or hands
- Leg pains when walking

II. HEAD & NECK

- Frequent headaches
- Neck pain
- Neck lumps or swelling
- Need glasses
- Blurry vision
- See double
- See halos
- Eye pain or watering
- Hearing difficulties
- Buzzing in ears
- Ear trouble
- Dental or gum trouble
- Soreness in mouth
- Hoarse voice
- Frequent nose bleeds

III. RESPIRATORY

- Shortness of breath
- Wheezing or asthma
- Cough up phlegm
- Cough up blood
- Pain in chest with breathing

IV. DIGESTIVE

- Difficulty in swallowing
- Heartburn
- Frequent belching
- Nausea or vomiting
- Vomiting blood
- Stomach pain
- Ulcer
- Constipation
- Diarrhea
- Loose stools
- Change in bowel habits
- Black or bloody bowel movements
- Rectal bleeding
- Rectal pain
- Liver trouble
- Yellow jaundice (hepatitis)
- Recent unintended weight loss
- Recent unintended weight gain

V. ENDOCRINE

- Thyroid disease
- Diabetes
- Change in skin or hair texture
- Change in tolerance to heat & cold

VI. URINARY-GENITAL

- Frequent urination (day/night)
- Burning on urination
- Difficulty starting urine
- Blood, protein, or sugar in urine
- Kidney stones
- Syphilis or gonorrhea
- Incontinence
- Sexual dysfunction

VII. FOR MALES

- Prostate problems
- Lumps or pain in testicles
- Discharge

VIII. FOR FEMALES

- Menstrual difficulties
- Excessive bleeding
- Vaginal discharge
- Vaginal bleeding
- Date of last menstrual period _____

IX. SKIN

- Recurrent rash
- Chronic itching
- Other skin problems _____

X. MUSCULOSKELETAL

- Aching muscles or joints
- Swollen joints
- Back or shoulder pain
- Arthritis
- Stiffness in joints
- Pain or cramping in the legs
- Weakness in arm
- Poor circulation

XI. NEUROLOGICAL

- Numbness or paralysis
- Convulsions
- Tremor or trembles
- Loss of appetite
- Insomnia
- Difficulty sleeping
- Difficulty with speech or memory
- Nervousness
- Depression
- Mood change or disturbance
- Anxiety
- Mania
- Hallucinations

XII. HEMATOLOGICAL

- Anemia or blood disorders
- Excessive bleeding or bruising
- Bleeding disorders
- Clotting problems

XIII. INFECTION

- Fever with night sweats