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 ANY ALLERGIES? □ YES □ NO

If yes, please list: _____

ALLERGY to 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	**□ YES □ NO**	**Month/Year:** _____
ECHOCARDIOGRAM	**□ YES □ NO**	**Month/Year:** _____
ULTRASOUND OF THE LEGS	**□ YES □ NO**	**Month/Year:** _____
CAROTID ULTRASOUND	**□ YES □ NO**	**Month/Year:** _____
RENAL ULTRASOUND	**□ YES □ NO**	**Month/Year:** _____
CARDIAC CATH	**□ YES □ NO**	**Month/Year:** _____
PTCA (ANGIOPLASTY)	**□ YES □ NO**	**Month/Year:** _____
STENTS	**□ YES □ NO**	**Month/Year:** _____
CORONARY ARTERY BYPASS	**□ YES □ NO**	**Month/Year:** _____
PACEMAKER IMPLANT	**□ YES □ NO**	**Month/Year:** _____
DEFIBRILLATOR IMPLANT	**□ YES □ NO**	**Month/Year:** _____
ABLATION	**□ YES □ NO**	**Month/Year:** _____
VALVE REPAIR	**□ YES □ NO**	**Month/Year:** _____
VALVE REPLACEMENT	**□ YES □ NO**	**Month/Year:** _____
If Yes, □ Mechanical or □ Pig Valve		

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

DIABETES	**□ YES □ NO**	**GOUT**	**□ YES □ NO**
ANEMIA	**□ YES □ NO**	**ARTHRITIS**	**□ YES □ NO**
STROKE	**□ YES □ NO**	**HIATAL HERNIA**	**□ YES □ NO**
CHEST PAIN	**□ YES □ NO**	**ULCER**	**□ YES □ NO**
PALPITATIONS	**□ YES □ NO**	**GALLBLADER DISEASE**	**□ YES □ NO**
HEART MURMUR	**□ YES □ NO**	**THYROID DISEASE**	**□ YES □ NO**
ABNORMAL EKG	**□ YES □ NO**	**KIDNEY DISEASE**	**□ YES □ NO**

RHEUMATIC FEVER	**□ YES**	**□ NO**	**LIVER DISEASE**	**□ YES**	**□ NO**
HIGH BLOOD PRESSURE	**□ YES**	**□ NO**	**BOWEL DISEASE**	**□ YES**	**□ NO**
BREATHING DIFFICULTY	**□ YES**	**□ NO**	**CANCER**	**□ YES**	**□ NO**
LIGHTHEADED/DIZZY	**□ YES**	**□ NO**	**SKIN LESSIONS**	**□ YES**	**□ NO**
HEART ATTACK	**□ YES**	**□ NO**	**PSYCHIATRIC DISEASE**	**□ YES**	**□ NO**
HIGH CHOLESTEROL	**□ YES**	**□ NO**	**UNEXPLAINED WEIGHT**	**□ YES**	**□ 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 Sons are living? _____ How many Sons 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?

_____

_____