



CIVA

THE CARDIOVASCULAR SPECIALISTS

PATIENT INFORMATION | HEALTH HISTORY

Please answer every question.

Date: _____

Name: _____ Date of Birth: _____ Age: _____
last first middle

Referring Physician: _____ in City: _____

Primary Care Physician: _____ in City: _____

REASONS FOR APPOINTMENT

___ Chest pain or pressure ___ High blood pressure ___ Shortness of breath ___ Pain/swelling in legs

___ Palpitations or fluttering/fast heart ___ Abnormal test ___ Dizziness or passing out

___ Pre-op evaluation _____

Other _____

Above problems have been occurring for _____ years, months, days (please circle)

MEDICAL HISTORY

ILLNESSES

___ Diabetes ___ High blood pressure ___ High cholesterol ___ Stroke (date: / /) ___ Atrial fibrillation

___ Congestive heart failure ___ Cancer ___ Heart attack (date: / /) ___ Low/high thyroid

___ Emphysema or asthma ___ Stomach ulcers

SURGERIES

___ Gall bladder (date: / /) ___ Appendix (date: / /) ___ Hysterectomy (date: / /) ___ Hernia (date: / /)

___ Heart by-pass (/ /) performed by Dr. _____ in City _____

___ Balloon angioplasty or stent (/ /) performed by Dr. _____ in City _____

___ Carotid artery (date: / /) ___ By-pass in legs (date: / /)

___ Other (date: / /) for _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

MEDICATIONS Please list all your medications, dosages, and how often taken:

DRUG ALLERGIES? ___ No ___ Yes, explain: _____

ALLERGIC TO DYE, IODINE, SEAFOOD? ___ No ___ Yes, explain: _____

SOCIAL HISTORY

Marital status: ___ Married (___ years) ___ Single ___ Divorced ___ Widowed Live with: ___ Alone ___ Spouse ___ Family/other

Smoke: ___ Never ___ In the past (date quit: / /) ___ Yes (___ packs/day for ___ years)

Alcohol: ___ No ___ Yes (___ drinks per week) Occupation (previous occupation if retired) _____

FAMILY HISTORY

PARENTS OR SIBLINGS WITH:

___ Heart disease (heart attack, angina, congestive heart failure, angioplasty, by-pass surgery)

___ Unexplained death _____

___ Congenital heart disease _____

TESTS Date Where Performed Result (if known)

Stress test _____

Echocardiogram _____

Heart catheterization _____

REVIEW OF HEALTH QUESTIONNAIRE

GENERAL

YES NO EXPLANATION

Fever

___ ___ _____

Weight loss

___ ___ _____

Fatigue

___ ___ _____

Increased thirst

___ ___ _____

Easy bleeding

___ ___ _____

HEAD AND EYES

New headaches

___ ___ _____

New vision loss

___ ___ _____

Blurred vision in one eye

___ ___ _____

HEART AND LUNGS

Chest pain

___ ___ _____

Short of breath

___ ___ _____

New cough

___ ___ _____

Wheezing

___ ___ _____

Can't lie flat

___ ___ _____

New swelling

___ ___ _____

GASTROINTESTINAL

Abdominal pain

___ ___ _____

Nausea

___ ___ _____

Diarrhea

___ ___ _____

Black stools

___ ___ _____

Blood in stools

___ ___ _____

GENITOURINARY

Burning with urination

___ ___ _____

Frequent urination

___ ___ _____

Frequent nighttime
urination

___ ___ _____

MUSCULOSKELETAL

Calf, thigh, or hip
pain with walking

___ ___ _____

Coldness or

numbness of feet

___ ___ _____

NEUROLOGICAL

New dizzy spells

___ ___ _____

Passed out

in past year

___ ___ _____

New weakness of

one arm or leg

___ ___ _____

Numbness

___ ___ _____

Signature: _____

Date: _____