CARDIOVASCULAR CONSULTANTS, LTD.

Health History

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

PCP: _____ **Referring Physician:** _____

Pharmacy Name: _____ **Phone:** _____

On Coumadin (Warfarin/Blood Thinner)? YES☐ NO☐ **Coumadin (Warfarin/Blood Thinner) Followed By:** _____

Has Pacemaker? YES☐ NO☐ **Brand:** _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATIONS:	DOSE:	TIMES PER DAY:	MEDICATIONS:	DOSE:	TIMES PER DAY:

WHAT OVER THE COUNTER MEDICATIONS, HERBAL MEDICATIONS OR SUPPLEMENTS ARE YOU TAKING?

MEDICATIONS:	REACTION:	MEDICATIONS:	REACTION:

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Health History Continued

WHAT MEDICATIONS DO YOU HAVE AN ALLERGIC REACTION TO?

MEDICATIONS:	REACTION:	MEDICATIONS:	REACTION:

HEALTH HISTORY

Check the box if you have a ***FAMILY HISTORY*** of the following: ( ) Father ( ) Mother ( ) Brother ( ) Sister

☐ Heart Attack ☐ Stroke ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol
☐ PVD, Abdominal Aortic Aneurysm ☐ Sudden Cardiac Death

Check the box if you have a ***PERSONAL HISTORY*** of any of the following:

☐ **Heart Surgery/Procedures**
☐ **Aneurysm Surgery**
☐ **Carotid Surgery** If yes, how is it treated? _____
☐ **Vascular Surgery/Procedures** If yes, how is it treated? _____
☐ **Diabetes** If yes, when? _____
☐ **High Blood Pressure** If yes, when? _____
☐ **High Cholesterol** If yes, when? _____
☐ **Stroke** If yes, when? _____
☐ **Palpatations** If yes, when? _____
☐ **Chest Pain** If yes, when? _____
☐ **COPD** If yes, how is it treated? _____
☐ **Congestive Heart Failure** If yes, when? _____
☐ **Asthma** If yes, when? _____

☐ How many alcoholic beverages do you consume each day? _____
☐ How many caffeinated beverages do you consume each day? _____
☐ Do you smoke? If so, how much each day? If you quit smoking, how long ago? _____
☐ Do you exercise? If so, how often and what type? _____
☐ Do you have a history of or currently use recreational drugs? If so, what type? _____
☐ Do you have advanced directives? If so, please provide us with a copy for your chart.

Please check any major hospitalization

☐ **Chest Pain** ☐ **Stroke** ☐ **High Blood Pressure**
☐ **Cardiac Complaint** ☐ **Fainting** ☐ **Peripheral Vascular Complaint**
☐ **Heart Attack** ☐ **Congestive Heart Failure** Name of Hospital: _____
☐ **Shortness of Breath** ☐ **Arrhythmia** Date: _____

Are there any other problems we should be aware of? _____