

NAME: _____ APPOINTMENT'S DATE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

1. What is the reason for your visit? _____

2. How long have you had this problem? _____

3. Please list your preferred local pharmacy (Name, Street, City) _____

Name of preferred mail-in pharmacy _____

PAST MEDICAL HISTORY (Please check any illness you have had)

- | | | |
|------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Abdominal Aortic Aneurysm | <input type="checkbox"/> Claudication | <input type="checkbox"/> ICD (Defibrillator) |
| <input type="checkbox"/> Abnormal Cholesterol | <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Abnormal Echocardiogram | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Left Bundle Branch Block |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Coumadin/Warfarin Use | <input type="checkbox"/> Mitral Valve Disease |
| <input type="checkbox"/> Abnormal Stress Test | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dizziness or Lightheadedness | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Aortic Valve Disease | <input type="checkbox"/> DVT (Blood clot in leg vein) | <input type="checkbox"/> Pulmonary HTN |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Edema (swelling in legs) | <input type="checkbox"/> Right Bundle Branch Block |
| <input type="checkbox"/> Atrial Flutter | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Carotid Stenosis (narrowing) w/stroke | <input type="checkbox"/> Heart Rhythm Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carotid Stenosis (narrowing) w/o stroke | <input type="checkbox"/> History of Heart Attack | <input type="checkbox"/> Syncope (Loss of conscience) |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> T.I.A. (mini stroke) |

Other _____

PAST SURGICAL HISTORY

Cardiovascular Surgeries

Date and Hospital

- | | |
|-------------------------------------------------------|-------|
| <input type="checkbox"/> Ablation | _____ |
| <input type="checkbox"/> Aneurysm Repair | _____ |
| <input type="checkbox"/> Angioplasty/Stent | _____ |
| <input type="checkbox"/> CABG/Bypass | _____ |
| <input type="checkbox"/> Carotid Surgery | _____ |
| <input type="checkbox"/> ICD/Pacemaker | _____ |
| <input type="checkbox"/> IVC Filter | _____ |
| <input type="checkbox"/> Valve Surgery | _____ |
| <input type="checkbox"/> Other Cardiovascular Surgery | _____ |

Other Surgeries

- | | | |
|------------------------------------------|--------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cataract | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Other Surgeries | _____ | |

MEDICATIONS (Please attach a list of all medications and doses)

ALLERGIES (List the medications you are allergic to)

Allergies: _____

FAMILY HISTORY (Please check any illnesses and how related)

	Father	Mother	Brother	Sister
___ Abdominal Aneurysm	___	___	___	___
___ Abnormal Cholesterol	___	___	___	___
___ Coronary Artery Disease	___	___	___	___
___ Diabetes	___	___	___	___
___ Heart Failure	___	___	___	___
___ History of Heart Attack	___	___	___	___
___ Hypertension (High Blood Pressure)	___	___	___	___
___ ICD (Defibrillator)	___	___	___	___
___ Pacemaker	___	___	___	___
___ Stroke	___	___	___	___
___ Syncope (Loss of consciousness)	___	___	___	___

SOCIAL HISTORY

Occupation _____

Tobacco Use: ___ Current Every day ___ Current Some ___ Former ___ Never
 If former tobacco user: Age Started ___ Age Stopped ___ How many Packs per day _____

Alcohol Use: ___ Current Every day ___ Current Some ___ Former ___ Never

Illicit Drug Use: ___ Current Every day ___ Current Some ___ Former ___ Never