Regional Cardiology Associates, P.L.C.

HEALTH HISTORY

Name: DATE:

D.O.B. AGE: WT HT REFERRING PHYS.

ALLERGIES:

CURRENT MEDICAL PROBLEM (Reason for Visit)

SOCIAL HISTORY

Marital Status ☐ M ☐ S ☐ D ☐ W

Occupation

Retired ☐ Yes ☐ NO

Alcohol Use Amount Freq.

Recreational Drugs Type Freq.

Smoker Amount Years

Prev. Smoker Years Year Quit

Exercise Freq.

PAST MEDICAL HISTORY

Surgeries

Bypass ☐ Yes ☐ No Year

Valve Surg. ☐ Yes ☐ No Year

Stent/Pacer/ICD ☐ Yes ☐ No Year

Have you had any of the following cardiac tests:

Stress Test ☐ Yes ☐ No Year

Echo ☐ Yes ☐ No Year

Carotid Doppler ☐ Yes ☐ No Year

Heart Cath ☐ Yes ☐ No Year

Other:

Cardiac Risk Factors

Are you currently being treated for:

High Blood Pressure ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Have you or anyone in your **immediate** family had:

Heart Attack? ☐ Yes ☐ No Self/ Mother/ Father/ Brother/ Sister (circle all that apply)

If yes at what age? Self Mother Father Brother Sister

Stroke? ☐ Yes ☐ No Self/ Mother/ Father/ Brother/ Sister (circle all that apply)

If yes at what age? Self Mother Father Brother Sister

Current Medication (continue on back if needed)

Medical Conditions (please check all that apply)

- ☐ chest pain or angina
- ☐ shortness of breath
- ☐ irregular heart beat
- ☐ dizziness/fainting
- ☐ lung/breathing problems
- ☐ pain during exercise, relieved by rest
- ☐ edema of feet, ankles or hands
- ☐ leg discomfort
- ☐ poor wound healing
- ☐ hair loss from toes/feet
- ☐ arthritis
- ☐ thyroid condition
- ☐ prostate/bladder/kidney problems
- ☐ paralysis/seizures
- ☐ rheumatic fever
- ☐ glaucoma
- ☐ cancer
- ☐ stomach ulcers/hernia
- ☐ liver/cirrhosis/hepatitis

Other Conditions: