Elite Cardiac & Vascular Care

HEALTH HISTORY FORM

Date: _____

PATIENT INFORMATION

Name: Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: Male Female

MAIN SYMPTOM OR PROBLEM

_____

_____

HAVE YOU HAD ANY OF THE ILLNESSES BELOW (Please check all that apply)

☐ High Blood Pressure	☐ Diabetes Mellitus	☐ High Cholesterol
☐ Stroke	☐ Heart Attack	☐ Rheumatic Fever
☐ Emphysema/COPD	☐ Sleep Apnea	☐ Heart Murmur
☐ Circulation Disorder	☐ Tuberculosis	☐ Cancer
☐ Bleeding Disorder	☐ Thyroid Disorder	☐ Hepatitis
☐ Asthma	☐ Ulcers	☐ Lung Disease
☐ Liver Disease	☐ Kidney Disease	

☐ Other : _____

LIST ALL PAST SURGERIES (including year of surgery)

_____

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

LIST CURRENT MEDICATIONS (including dose and how often it is taken)

_____

_____

_____

_____

_____

LIST ALL ALLERGIES TO MEDICATIONS (including type of reaction to medication)

_____

_____

_____

_____

Are you allergic to shellfish or X-ray dye or iodine dye: ☐ Yes ☐ No

LIST FAMILY HISTORY OF ANY MEDICAL PROBLEMS

_____

_____

_____

_____

IF YOU ARE EXERCISING, please list the type of exercise, frequency, and duration

_____

_____

_____

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

Have you ever smoked? ☐ Yes ☐ No If yes, for how many yaers? _____

If you stopped smoking, how long ago? _____ What age did you start? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

If female, are you still menstruating? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If not pregnant, do you use birth control? ☐ Yes ☐ No

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS

Chest Pain	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Swelling / Edema	☐ Yes	☐ No
Palpitations (Heart pounding or racing)	☐ Yes	☐ No
Dizziness / Lightheadedness	☐ Yes	☐ No
Passing out / Loss of Consciousness / Fainting	☐ Yes	☐ No
Leg Pain with Walking	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Sweats	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Blood Tinged Sputum	☐ Yes	☐ No
Unexplained Weight Gain or Loss	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No
Bloody or Black Stools	☐ Yes	☐ No
Jaundice or Hepatitis	☐ Yes	☐ No
Easy Bruising or Bleeding	☐ Yes	☐ No

Print Patient's Name: _____

Patient's Signature: _____ Date: _____

Signature of Legal Representative: _____ Relationship to Patient: _____

Doctor's Signature: _____ Date: _____