East Valley Cardiology

Specializing in Diseases of the Cardiovascular System

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Patient Medical History Form

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

Referring Physician: _____ **Preferred Hospital:** _____

Preferred Pharmacy: _____ **Preferred Pharmacy Phone:** _____

Preferred Pharmacy Address: _____

Reason for Visit: _____

Current Medication: Please list all current medications you are taking, including dosage and frequency.

Medication Name	Dosage	Frequency

Allergies: Please check the box if you have ever had an allergic reaction to any of the following:

☐ Intravenous dye ☐ Shellfish ☐ Iodine

Other allergic reactions:

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Personal Medical History: Has the patient had any of the following medical conditions?

Cardiac Risk Factors:

☐ High cholesterol/triglycerides ☐ High blood pressure (hypertension) ☐ Diabetes Mellitus

Heart History:

	Date	**Physician**	**Hospital**
☐ Heart Attack	_____	_____	_____

☐ Atrial Fibrillation
☐ Arrhythmia (Irregular beats)
☐ Congestive Heart Failure
☐ Coronary Artery Disease (blocked arteries)
☐ Heart Murmur
☐ Mitral valve prolapse
☐ Pericarditis
☐ Peripheral vascular disease
☐ Thromboembolic Disease (hx of clots)
☐ Valvular Disease

Vein History:

☐ Varicose Veins
☐ Edema (Swelling)**
☐ Pain Upon Standing**
☐ Venous Reflux
☐ Throbbing legs**
☐ Pain Upon Ambulation/Activity**

Neurological History:

☐ Stoke
☐ Fainting
☐ Migraine Headache
☐ Neuropathy
☐ Transient Ischemic Attack

Pulmonary & Endocrine History:

☐ Asthma
☐ Bronchitis**
☐ COPD
☐ Emphysema**
☐ Hyperthyroidism (overactive thyroid)
☐ Hypothyroidism (underactive thyroid)
☐ Obesity

Gastroenterology History:

☐ Blood in the stool**
☐ GERD
☐ Hepatitis
☐ Hiatal hernia
☐ Peptic ulcer
☐ Vomit containing blood**

Other History:

☐ Bleeding Disorder
☐ Cancer
☐ HIV Infection
☐ Intravenous drug use
☐ Renal/Kidney failure
☐ Rheumatic fever
☐ Other: _____

Non-Cardiac Procedure/Surgery History: Please list past surgeries and include approximate date.

Surgery	Date (if known)

Cardiac Tests/Surgery History: Please check ☒ to indicate if the patient has had any of the following.

Cardiac Test/Surgery	Date (if known)	Physician
☐ EKG		
☐ Treadmill Stress Test		
☐ Nuclear Stress Test		
☐ Echocardiogram		
☐ Arterial Doppler		
☐ Aortic Ultrasound		
☐ Carotid Ultrasound		
☐ ABI Testing		
☐ Venous Ultrasound		
☐ Cardiac Catheterization		
☐ Coronary Intervention/Stent		
☐ TAVR		
☐ Mitral Valve Clip		
☐ Cardiac Pacemaker		
☐ ICD/Defibrillator		
☐ Arrhythmia Ablation		
☐ Coronary Artery Bypass		
Number of bypasses:		
☐ Cardiac Valve Surgery		
Which valve(s):		
☐ Peripheral Vascular Intervention		
☐ Peripheral Vascular Surgery		
☐ Carotid Artery Surgery/Stent		
☐ Vein Ablation		
☐ Vein Extraction		
☐ Other:		

Social History:

Smoker (cigarettes): ☐ Yes ☐ No ☐ Quit How many packs per day? _____

Alcohol use: ☐ Yes ☐ No ☐ Socially How many drinks per day? _____

Illicit Drugs use: ☐ Yes ☐ No What type/how often? _____

Exercise: ☐ Yes ☐ No How often? _____/week

Type of exercise: _____

Activities/Hobbies: _____

Personal History:

Place of Birth: _____ Marital Status: _____

Occupation: _____ Number of Children: _____

Family History: Has the patient's family had any of the following medical conditions?

☐ Bleeding Disorders ☐ Diabetes Mellitus ☐ Family History Is Unknown

☐ Clotting Disorders ☐ Thyroid Disorder ☐ Patient is Adopted

Cardiac Family History: Has the patient's family had any of the following cardiac conditions?

Heart Disease	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				
Coronary Artery Disease	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				
Cardiac Failure	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				
Congestive Heart Failure	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				
High Cholesterol	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				
High Blood Pressure	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				
Stroke	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				
Other Condition:	☐ Parent	☐ Sibling	☐ Child	☐ Other:
Age of Onset:				