



East Valley Cardiology, LTD.

Specializing in Diseases of the Cardiovascular System

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Chandler, AZ 85224

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
<input type="checkbox"/> Heart Attack	_____	_____	_____
<input type="checkbox"/> Atrial Fibrillation			<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Arrhythmia (Irregular beats)			<input type="checkbox"/> Pericarditis
<input type="checkbox"/> Congestive Heart Failure			<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Coronary Artery Disease (blocked arteries)			<input type="checkbox"/> Thromboembolic Disease (hx of clots)
<input type="checkbox"/> Heart Murmur			<input type="checkbox"/> Valvular Disease

Vein History:

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

Neurological History:

Stroke Neuropathy
 Fainting Transient Ischemic Attack
 Migraine Headache

Pulmonary & Endocrine History:

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

Gastroenterology History:

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

Other History:

Bleeding Disorder Intravenous drug use
 Cancer Renal/Kidney failure
 HIV Infection 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
<input type="checkbox"/> EKG		
<input type="checkbox"/> Treadmill Stress Test		
<input type="checkbox"/> Nuclear Stress Test		
<input type="checkbox"/> Echocardiogram		
<input type="checkbox"/> Arterial Doppler		
<input type="checkbox"/> Aortic Ultrasound		
<input type="checkbox"/> Carotid Ultrasound		
<input type="checkbox"/> ABI Testing		
<input type="checkbox"/> Venous Ultrasound		
<input type="checkbox"/> Cardiac Catheterization		
<input type="checkbox"/> Coronary Intervention/Stent		
<input type="checkbox"/> TAVR		
<input type="checkbox"/> Mitral Valve Clip		
<input type="checkbox"/> Cardiac Pacemaker		
<input type="checkbox"/> ICD/Defibrillator		
<input type="checkbox"/> Arrhythmia Ablation		
<input type="checkbox"/> Coronary Artery Bypass		
Number of bypasses:		
<input type="checkbox"/> Cardiac Valve Surgery		
Which valve(s):		
<input type="checkbox"/> Peripheral Vascular Intervention		
<input type="checkbox"/> Peripheral Vascular Surgery		
<input type="checkbox"/> Carotid Artery Surgery/Stent		
<input type="checkbox"/> Vein Ablation		
<input type="checkbox"/> Vein Extraction		
<input type="checkbox"/> 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	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				
Coronary Artery Disease	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				
Cardiac Failure	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				
Congestive Heart Failure	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				
High Cholesterol	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				
High Blood Pressure	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				
Stroke	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				
Other Condition:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Age of Onset:				