HEALTH HISTORY

NAME: ____

Referring Physician with address/phone:

Dr.____

Reason for appointment: *(check all that apply)*

__ Chest Pain/Angina __ Heart Attack __ High Blood Pressure

__ Shortness of Breath __ Abnormal Test __ Congestive Heart failure

__ Dizziness/Passing out __ Palpitations __ Pre-op Evaluation

__ Heart Murmur/Valve Problem __ Cardiac arrest __ Stent/Angioplasty

__ Heart Surgery/CABG/Valve Surgery __ Pain in Legs with Walking/Claudication

Other illness:

__ Diabetes __ High Cholesterol __ Heart Attack __ Emphysema/COPD

__ Kidney Problems __ Stomach Problems/Ulcers __ Pneumonia __ Stroke/CVA/TIA

Allergies *(list medications & reactions):*

Allergy to iodine contrast? __Yes __ No
Latex?__ Yes __No

Current medications: *(Please include name, dose and frequency)*

Name	Dose	Frequency

Do you take aspirin daily?

Smoking:

__Never __Quit _____Year? __Current Smoker : ____Packs a day for ____yrs.

Alcohol use *(How often):*

Family history of cardiac disease or stroke:

Please list any recent heart tests such as stress tests or echocardiograms *(include date and location):*

Please list all surgeries or procedures *(include hospital and date):*

Heart By-Pass/CABG/Valve Surgery/Pacemaker:

	Hospital	Date

Angiogram or Angioplasty:

	Hospital	Date