Texas Health
Heart & Vascular Specialists

Date Seen: _____

Name: _____ DOB_____ MR# _____ Sex: ____

What is the name of the doctor who referred you to us? _____Name of your family MD _____

WHY ARE YOU HERE to see a Cardiology heart doctor? _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

Mark X on any HEART PROBLEMS or SYMPTOMS:

- ☐ Chest pains or pressure
- ☐ Angina
- ☐ Heart attack
- ☐ Heart failure
- ☐ Enlarged heart
- ☐ Abnormal rhythm arrhythmias
- ☐ Palpitations/Irregular heart beat
- ☐ Heart murmur
- ☐ Blue lips or fingernails
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Fainting
- ☐ Leg cramps when you walk
- ☐ Swollen legs

Have you ever had -

Diabetes	☐ Yes	☐ No	Overweight	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No			
High Cholesterol	☐ Yes	☐ No	TOTAL_____ LDL_____ HDL_____ Trig _____		
High triglycerides	☐ Yes	☐No			
Have you ever smoked?	☐ Yes	☐ No	Year Quit _____ Packs/day _____ How long _____		

Has a close family member had: Mother – Father – Sibling

			Age Occurred	Cause of Death
A heart attack?	☐ Yes	☐ No	_____	_____ ☐
Angina?	☐ Yes	☐ No	_____	_____ ☐
Bypass surgery?	☐ Yes	☐ No	_____	_____ ☐
Carotid surgery?	☐ Yes	☐ No	_____	_____ ☐
Surgery of leg arteries?	☐ Yes	☐ No	_____	_____ ☐

Mark X if you have ever had any of the following PROCEDURES: Indicate approximate year of the procedure

- ☐ Stress test _____
- ☐ Coronary bypass surgery _____
- ☐ Valve surgery _____
- ☐ Electrocardiogram_____
- ☐ Electrophysiology Study or Procedure _____
- ☐ Cardiac catheterization / Heart catheterization _____
- ☐ Pacemaker or Defibrillator _____
- ☐ Coronary Angioplasty balloon arthrectomy / stent _____

Please list all illnesses you are being treated for now or have you been treated for. Please include date or year

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list all injuries or surgeries you have had. Please include date or year

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Name: _____ **DOB**:_____ **Date Seen**:_____

Social History:

Cardiac Hx

☐ CAD ☐ CHF/CM

☐ Arrhythmia ☐ PVD

☐ Valve Congen ☐ Other

HPI

Onset _____

Frequency _____

Location _____

Risk Fx

PMH

DOCTOR TO FILL OUT

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MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse name _____

CHILDREN: ☐ Yes ☐ No # of Sons _____ # of Daughters _____

OCCUPATION: _____

DIET: ☐ Regular ☐ No Added Salt ☐ Low Salt ☐ Low Fat / Chol ☐ Diabetic
☐ Other: _____

ALCOHOL USE: ☐ Yes ☐ No ☐ Former Year Quit _____
☐ Rarely ☐ Frequently ☐ Socially ☐ Occasionally ☐ Daily

EXERCISE: ☐ Sedentary ☐ Occasionally ☐ Regularly ☐ Active Lifestyle ☐ Physically Unable

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

Social Hx Family Hx

Medications

Please tell us about your medicines names, dose or strength, how many times a day.
Include over the counter medications and herbal medicines. Use doctor's column if necessary.

	Name	Dose	Frequency
1.	ASPIRIN **YES** ☐ **NO** ☐	81mg ☐ 325mg ☐	Enteric Coated YES ☐ NO ☐
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
Over the Counter Medications / Herbs			
1.			
2.			
3.			
4.			

Allergies

Allergies:
Do you have any **DRUG ALLERGIES**? ☐ Yes ☐ No If yes, list them below

_____

_____

Are you allergic to IODINE, shrimp or shellfish? ☐ Yes ☐ No

Vaccinations

Have you ever had a reaction to contrast dye? e.g. Myelogram, Kidney Series, CAT Scan ☐ Yes ☐ No

Have you had the following vaccinations? ☐ Influenza "Flu Shot" ☐ Annually ☐ Pneumococcal "Pneumonia" vaccine

Date:_____

Name:_____

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Date of Birth:_____

Please **circle** if you have any of the following symptoms in the last 1-2 weeks:

CONSTITUTION	EYES	GASTROINTESTIONAL	ENDO/HEME/ALLERGY
Fever	Blurred Vision	Heartburn	Easy Bruising
Chills	Double Vision	Nausea	Allergies
Weight Loss	Sensitive to Light	Vomiting	Excessive Thirst
Fatigue	Eye Pain	Abdominal Pain	**NEUROLOGICAL**
Sweating/Perspiration	Eye Discharge	Diarrhea	Dizziness
Weakness	Eye Redness	Constipation	Tingling
SKIN	**CARDIOVASCULAR**	Blood in Stool	Tremor
Rash	Chest Pain	Black Stool	Sensory Change
Itching	Palpitations/Flutter	**GENITOURINARY**	Speech Change
HENT	Shortness of breath lying down	Painful Urination	Focal Weakness
Headaches	Leg Cramps	Urgency	Seizures
Hearing Loss	Leg Swelling	Urinary Frequency	Loss of Consciousness
Ringing in Ears	Waking from Sleep Short of Breath	Blood in Urine	**PSYCHIATRIC**
Ear Pain	**RESPIRATORY**	Flank Pain	Depression
Ear Discharge	Cough	**MUSCULOSKELETAL**	Suicidal Ideas
Nosebleeds	Coughing up Blood	Muscle Pain	Substance Abuse
Congestion	Sputum Production	Neck Pain	Hallucinations
Sore Throat	Short of Breath	Back Pain	Nervous/Anxious
	Wheezing	Joint Pain	Insomnia
		Falls	Memory Loss