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| <input type="checkbox"/> Joseph M. Ortenberg, MD, FACC | <input type="checkbox"/> Carl J. Horton, MD, FACC | <input type="checkbox"/> Robbin Quillin, RN, MSN, AGACNP |
| <input type="checkbox"/> Theodore S. Takata, MD, FACC | <input type="checkbox"/> Nathan J. Lo, MD | |

INITIAL OFFICE VISIT

Date of service: _____ Age: _____ Sex: Male Female
 Patient name: _____ Date of birth: _____
 Primary Care Physician: _____ MD requesting visit: _____

Welcome to Texas Health Heart & Vascular Specialists
 We are pleased to have you as a new patient and hope that your experience with us is a pleasant one. We strive to provide you with the highest quality of care. In doing so, our physicians extenders need to have the most comprehensive history possible. Please complete the following questions to the best of your ability.

Thank You

REASONS FOR VISIT/CHIEF COMPLAINT: (why is it that you need or want to see the specialist? What symptoms or sensations have you been experiencing?)

SOCIAL HISTORY:

What is your occupation? _____
 What is your marital status? _____
 Do you have children? Yes No If yes, how many? _____

TOBACCO & ALCOHOL HISTORY:

Do you smoke? Yes No
 If no, Did you ever smoke? Yes No How many years did you smoke? _____
 What year did you quit? _____ How many packs per day did you smoke? _____
 Do you drink alcohol? Yes No
 If no, Did you ever drink alcohol? Yes No
 How many drinks would you consume in an average week? _____
 In what year did you stop consuming alcohol? _____
 If yes, How many drinks do you consume in an average week? _____

MEDICATIONS:

(please bring medication bottles with you to all visits)

Medication	Dose	Frequency

ALLERGIES:

Are you allergic to medications? Yes No

List: _____

Are you allergic to IODINE/X-RAY DYE? Yes No

Are you allergic to shellfish? Yes No

Are you allergic to FOODS? Yes No

List: _____

PAST MEDICAL HISTORY: (please check, place year you were diagnosed.)

Cardiac/Vascular

- Aneurysm _____
- Angina/Chest Pain _____
- Aortic Aneurysm _____
- Arrhythmia _____
- Atrial Fibrillation or Flutter _____
- Carotid Artery Disease _____
- Cardiomyopathy _____
- Claudication _____
- Congestive Heart Defect (born with) _____
- Congestive Heart Failure _____
- Coronary Artery Disease _____
- DVT/Deep Vain Thrombosis _____
- Heart Attack _____
- Heart Murmur _____
- Heart Valve Disease _____
- High Blood Pressure _____
- High Cholesterol _____
- Pericarditis _____
- Peripheral Vascular Disease _____
- Stroke _____
- TIA (mini-stroke or Temporary stroke) _____
- Varicose Veins _____
- Other: _____

Endocrine

- Adrenal Gland Disorder _____
- Diabetes _____
- Goiter _____
- Hyperthyroidism (high) _____
- Hypothyroidism (low) _____
- Other: _____

Infectious Disease

- CMV/Cytomegalovirus _____
- Cholelithiasis _____
- Endocarditis _____
- HIV/AIDS _____
- Lyme Disease _____
- MRSA/Methicillin Resistant Staph Aureus _____
- Rheumatic Fever _____
- Shingles _____
- Sexually Transmitted Infection _____
- Tuberculosis/TB _____

PAST MEDICAL HISTORY: (continued)

Gastrointestinal

- Chronhn's Disease _____
- Cholelithiasis _____
- Cirrhosis _____
- Colitis _____
- Diverticulitis _____
- Gastroesophageal Reflux _____
- GI Bleed _____
- Hepatitis B _____
- Hepatitis C _____
- Hiatal Hernia _____
- Ischemic Bowel _____
- Peptic Ulcer Disease _____
- Stomach Ulcers _____

Musculoskeletal

- Carpal Tunnel _____
- DJD/Degenerative Joint Disease _____
- Fibromyalgia _____
- Gout _____
- Herniated Disk _____
- Osteoarthritis _____
- Rheumatoid Arthritis _____
- Reptured Disk _____
- Spinal Stenosis _____
- Other: _____

Family History:

Have any of your relatives been diagnosed with:

- | | | |
|---|--|---|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Angioplasty |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Strokes | <input type="checkbox"/> TIA's |
| <input type="checkbox"/> Enlarged Heart | <input type="checkbox"/> Hypertrophic Cardiomyopathy | |
| <input type="checkbox"/> Long QT Syndrome | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Sudden Cardiac Death |
| <input type="checkbox"/> Blocked Arteries (elsewhere in the body) | | <input type="checkbox"/> Marfan's Syndrome |
| <input type="checkbox"/> Peripheral Vascular Disease | | |

What type of health conditions exist/existed in your

Mother : _____

Father : _____

Siblings: _____

Maternal Grandparents: _____

Paternal Grandparents: _____

Aunts, Uncles, Cousins: _____

Continue Surgical History

- ORIF/Open Reduction Internal Fixation _____
- Prostatectomy _____
- Splenectomy _____
- Thyroidectomy _____
- Tonsillectomy/Adenoidectomy _____
- Total Hip Replacement _____
- Total Knee Replacement _____
- Tubal Ligation _____
- TURP _____
- Vasectomy _____

Past Surgical History

- Aneurysm Repair _____
- Angioplasty/PTCA _____
- Appendectomy _____
- Breast Augmentation _____
- Breast Biopsy _____
- Carotid Artery Endarterectomy _____
- Cartaract Removal Right Left _____
- Cervical Fusion _____
- Cholecystectomy _____
- Colectomy _____
- Coronary Artery Bypass (CABG) _____
- Craniotomy _____
- Dialysis Access _____
- Discectomy _____
- Gastric Bypass _____
- Hernia Repair _____
- Hysterectomy _____
- Inguinal Hernia Repair _____
- Kidney Stone Treatment _____
- Knee Surgery _____
- Laminectomy _____
- Mastectomy _____