St David's Heart & Vascular

MEDICAL HISTORY QUESTIONNAIRE

IF IT HAS BEEN THREE OR MORE YEARS SINCE YOUR LAST VISIT, COMPLETE THE ENTIRE FORM
IF LESS THAN THREE YEARS, PLEASE UPDATE AREAS THAT HAVE CHANGED SINCE THE LAST VISIT

Patient Name_____Appt. Date_____ Date of Birth_____ Age_____

Primary Care Doctor_____

DO YOU HAVE A LIVING WILL OR A MEDICAL POWER OF ATTORNEY? ◯ **YES** ◯ **NO**
HAVE YOU HAD THIS SEASON'S FLU IMMUNIZATION ◯ **YES** ◯ **NO** **DATE**_____
HAVE YOU HAD YOUR PNEUMONIA IMMUNIZATION ◯ **YES** ◯ **NO** **DATE**_____

Please check anything you have been diagnosed with:

PAST MEDICAL HISTORY

- ◯ Aortic aneurysm
- ◯ A-Fib
- ◯ Anemia
- ◯ Angina
- ◯ Arrhythmia
- ◯ Asthma
- ◯ Cancer
- ◯ Cardiomyopathy
- ◯ Carotid disease
- ◯ Heart Failure
- ◯ Clotting disorder
- ◯ Coronary artery disease
- ◯ Diabetes
- ◯ Heart murmur
- ◯ High cholesterol
- ◯ High blood pressure
- ◯ Kidney disease
- ◯ Heart attack
- ◯ Peripheral arterial disease
- ◯ Sleep apnea
- ◯ Stroke/TIA
- ◯ Syncope (fainting)
- ◯ Thyroid disease
- ◯ Varicose/Spider Veins

OTHER MEDICAL HISTORY

- ◯ Anxiety
- ◯ Arthritis
- ◯ Blood clots in veins/lungs
- ◯ COPD/Emphysema
- ◯ Depression
- ◯ Easy bruising/bleeding
- ◯ HIV/AIDS
- ◯ Liver problems/Hepatitis
- ◯ Menopause
- ◯ _____
- ◯ Phlebitis/Swelling
- ◯ Rheumatic fever
- ◯ Stomach/Intestinal ulcers
- ◯ Tuberculosis
- ◯ _____

PAST CARDIAC SURGERIES

- ◯ AAA repair
- ◯ Cardiac ablation
- ◯ ASD repair
- ◯ Coronary bypass
- ◯ Cardiac catheterization
- ◯ Cardioversion
- ◯ Carotid stent
- ◯ Coronary stent
- ◯ ICD
- ◯ _____
- ◯ LARIAT
- ◯ Pacemaker
- ◯ Peripheral stent
- ◯ Valve repair/replacement
- ◯ _____

OTHER SURGICAL HISTORY

○ Appendectomy	○ Fracture repair	○ Knee replacement
○ Carpel tunnel release	○ Gall bladder	○ Knee surgery
○ Cataract	○ Hip replacement	○ Tonsils/Adenoids
○ C-section	○ Hysterectomy	○ Vasectomy/Tubal ligation
○ _____	○ _____	○ _____

FAMILY HISTORY

Relationship	*Alive/Deceased*	*Arrhythmia*	*Coronary artery disease*	*Clotting disorder*	*Diabetes*	*Heart attack*	*Heart disease*	*Heart failure*	*High cholesterol*	*High blood pressure*	*Stroke/TIA*	*Sudden cardiac death*	*Varicose veins*	*Venous insufficiency*
Mother														
Father														
Sister														
Brother														
Mat Aunt														
Mat Uncle														
Pat Aunt														
Pat Uncle														
MGM														
MGF														
PGM														
PGF														

○ Adopted ○ Family History Unknown

SOCIAL HISTORY

Do you drink alcoholic beverages? ◯ Yes ◯ No

How many drinks per week? ____ glasses of wine
____ cans of beer
____ shots of liquor
____ mixed drinks

Do you use illegal drugs/abuse prescription drugs? ◯ Yes ◯ No If yes which drugs? _____
How often? _____

Have you ever been a smoker? ◯ Never ◯ Former, quit date _____ ◯ Current smoker
Years smoked _____ Packs per day _____

Do you use smokeless tobacco? ◯ Never ◯ Former, quit date _____ ◯ Current user
Years used _____ Uses per day _____

If you smoke/use tobacco, are you ready to quit? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you drink caffeine? ◯ Yes ◯ No

ALLERGIES

Have you had a reaction to X-Ray contrast dye? ◯ Yes ◯ No

Are you allergic to iodine or shellfish? ◯ Yes ◯ No

Are you allergic to any medications? ◯ Yes ◯ No

If yes, please list medication names_____