THE HEART CARE GROUP, P.C.
MEDICAL HISTORY RECORD

NAME_____

BIRTH DATE_____ TODAY'S DATE_____

PLEASE DESCRIBE YOUR CURRENT PROBLEM:_____

_____

_____

_____

MEDICATIONS:_____

_____

_____

DRUG ALLERGIES:_____

_____

DO YOU HAVE ANY OF THE FOLLOWING RISKS:

YES _____ NO _____ CIGARETTE SMOKING, IF YES, HOW MUCH_____HOW LONG_____

YES _____ NO_____ HIGH BLOOD PRESSURE

YES _____ NO_____ HIGH CHOLESTEROL/TRIGLYCERIDES

YES _____ NO_____ DIABETES

YES _____ NO_____ FAMILY HISTORY OF HEART DISEASE

YES _____ NO _____ INACTIVE LIFESTYLE

HABITS – DO YOU...

DRINK COFFEE?	YES _____ NO _____	CUPS EACH DAY: _____
DRINK SODA?	YES _____ NO _____	CANS EACH DAY: _____
DRINK ALCOHOL?	YES _____ NO _____	FREQUENCY: _____
EXERCISE?	YES _____ NO _____	_____TIMES PER WEEK
EAT A SPECIAL DIET?	YES _____ NO _____	_____
RECREATIONAL DRUGS?	YES _____ NO _____	

HAVE YOU EVER HAD ANY OF THE FOLLOWING SERIOUS MEDICAL ILLNESSES?

YES _____ NO _____	HEART ATTACK	YES _____ NO _____	KIDNEY DISEASE
YES _____ NO _____	CONGESTIVE HEART FAILURE	YES _____ NO _____	BLOOD CLOT IN LUNGS
YES _____ NO _____	LUNG DISEASE	YES _____ NO _____	HIGH BLOOD PRESSURE
YES _____ NO _____	DIABETES	YES _____ NO _____	GOUT
YES _____ NO _____	BLEEDING TENDENCY	YES _____ NO _____	STROKE
YES _____ NO _____	ULCERS OR HIATAL HERNIA	YES _____ NO _____	LIVER DISEASE
YES _____ NO _____	COLITIS OR OTHER BOWEL DISEASE	YES _____ NO _____	CANCER
YES _____ NO _____	RHEUMATIC FEVER, SCARLET FEVER	YES _____ NO _____	ANXIETY OR DEPRESSION
YES _____ NO _____	EMPHYSEMA, BRONCHITIS, ASTHMA	YES _____ NO _____	THYROID PROBLEM

PLEASE LIST ALL PREVIOUS OPERATIONS AND SERIOUS ILLNESSES: _____

_____

_____

_____

_____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS?

YES _____ NO _____ CHEST DISCOMFORT, SQUEEZING, TIGHTNESS, PAIN

YES _____ NO _____ PALPITATIONS, SKIPPED OR RAPID HEARTBEATS

YES _____ NO _____ LIGHT-HEADEDNESS OR DIZZINESS

YES _____ NO _____ FAINTING SPELLS

YES _____ NO _____ SHORTNESS OF BREATHE WHEN LYING DOWN FLAT

YES _____ NO _____ WAKE UP AT NIGHT SHORT OF BREATH

YES _____ NO _____ SHORTNESS OF BREATH AT REST OR WITH EXERTION

YES _____ NO _____ SWELLING OF HANDS, FEET, OR ANKLES

YES _____ NO _____ CHRONIC OR FREQUENT COUGH

YES _____ NO _____ FEVER OR CHILLS

YES _____ NO _____ "HEARTBURN" OR BELCHING

YES _____ NO _____ WEIGHT GAIN OR LOSS

YES _____ NO _____ PAIN IN LEGS WHEN WALKING OR AT NIGHT

HAVE YOU EVER HAD THE FOLLOWING CARDIAC PROCEDURES?

LOCATION/DATE

YES _____ NO _____ ELECTROCARDIOGRAM (EKG) _____

YES _____ NO _____ ECHOCARDIOGRAMS_____

YES _____ NO _____ STRESS TEST_____

YES _____ NO _____ CARDIAC CATHETERIZATION_____

YES _____ NO _____ BALLOON ANGIOPLASTY_____

YES _____ NO _____ HEART SURGERY_____

PLEASE DESCRIBE ANY ADDITIONAL PROBLEMS YOU FEEL WE SHOULD KNOW ABOUT, OR WHICH YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR:_____

_____

_____

_____

_____

_____

_____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person unless authorization is given to us by you.