Advanced Heart and Vascular Medicine

Diagnostic and Interventional Cardiology
1631 11th St, Suite A, Wichita Falls, TX 76301
(Office) 940-263-3003 (Fax) 940-263-3009

Patient Name: _____ Date: _____

Home Medications:

List all medications & dosage you are presently taking and how frequently you take them:

Medication/Dose/Frequency:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all known allergies

_____
_____
_____

FAMILY HISTORY

Please check and add any details out to the side

- Aortic Aneurysm [father, mother, sibling, grandparent]
- Asthma [father, mother, sibling, grandparent]
- Bleeding Disorder [father, mother, sibling, grandparent]
- Cancer…….. [father, mother, sibling, grandparent]
- Congestive Heart Failure [father, mother, sibling, grandparent]
- Connective Tissue Disease [father, mother, sibling, grandparent]
- Coronary Artery Disease [father, mother, sibling, grandparent]
- Coronary Artery Disease-male<55 [father, mother, sibling, grandparent]
- Coronary Artery Disease- female<55 [father, mother, sibling, grandparent]
- CVA or Stroke [father, mother, sibling, grandparent]
- Diabetes [father, mother, sibling, grandparent]
- Hyperlipidemia [father, mother, sibling, grandparent]
- Hypertension [father, mother, sibling, grandparent]
- Marfan`s Syndrome [father, mother, sibling, grandparent]
- Pulmonary Artery Hypertension [father, mother, sibling, grandparent]
- Peripheral vascular disease [father, mother, sibling, grandparent]
- Prolonged QT [father, mother, sibling, grandparent]
- Renal Disease [father, mother, sibling, grandparent]
- Sudden Cardiac Death [father, mother, sibling, grandparent]
- Thyroid Disease [father, mother, sibling, grandparent]

Mother living? Yes No Age at death _____ Father living? Yes No Age at death _____ Number of living brothers & _____ Number of deceased brothers & sisters _____

SOCIAL HISTORY:

Marital Status: Single/Married/Divorced/Widowed
How many children do you have? _____
What is your occupation: _____
Disabled Retired

Smoking History:
Current Smoker: Year started _____
Cigarettes:_____ packs per day
Cigars: _____ number per day
Smokeless: _____ amount per day
Counseled to quit or cut down: Yes No
Former Smoker: Year quit _____

Never smoked:

Passive smoke exposure: Yes No
Do you drink alcoholic beverages? Yes No
Types of Alcohol? _____
How many drinks per day? _____

Drugs Use? Yes No (if yes circle type below)

Marijuana, cocaine, crack, heroin, illicit, prescription
Other: _____

Do you drink caffeinated drinks? Yes No
How many per day?_____
Do you drink diet drinks? Yes No

Are you on a special diet? Yes No
Calorie Limited Low Salt
Low Fat Diabetic
High Fibre Low Cholesterol
Other_____

Do you exercise on a regular basis? Yes No
How many times per week? _____
Type of exercise? _____

Do you have a barrier to communicate? Yes No

High Risk Behaviour? Yes No
Comments: _____