



Cardiovascular Disease and Invasive Cardiology

Patient History

Date _____

Name _____ Date of Birth _____ Age _____ Referring physician _____

Reason for referral _____

Have you been seen by a Cardiologist before Y/N If yes, please list name/date _____

Marital Status: M ___ D ___ S ___ W ___ #yrs ___ Work ___ Retired ___ Occupation _____

Smoke: No ___ Yes ___ #packs per day ___ #yrs ___ Alcohol: No ___ Yes ___ Amount _____

Caffeine (#cups per day): Coffee ___ Tea ___ Soft drinks ___ Diet/Appetite _____

Height _____ Weight _____ Recent loss/gain _____ Exercise _____

Allergies (include reaction) _____

List all medications including over the counter and dietary supplements:

Name	Dose	How often?

Name	Dose	How often?

Family History	Living or cause of death	Heart Disease	Diabetes	Cancer
Mother				
Father				
Child				
Child				
Child				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				



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List any surgeries you have had, please include dates.

System Review: Please circle all that apply to you.

Neurological: Dizziness, Headaches, Loss of sensation, other-describe _____

Eyes/Ears: Glasses or Contacts, Glaucoma, Hearing loss, other-describe _____

GI: Indigestion, GERD, Heatal hernia, Diarrhea, Constipation, other-describe _____

Endocrine: Diabetes, hypo or hyperthyroidism, other-describe _____

Musculoskeletal: Arthritis, Joint pain, Muscle pain or weakness, other-describe _____

Respiratory: Asthma, COPD, Shortness of breath, other-describe _____

Cardiovascular: High blood pressure, heart disease, irregular or rapid heartbeat, Pacemaker, AICD, heart failure,

Leg cramps while walking, other-describe _____

Please indicate which of these procedures you have had, including date and location:

EKG _____ Echocardiogram _____

Holter or Event Monitor _____ Heart Catheterization _____

Angioplasty or stent(s) _____ Heart Surgery _____

Signature _____

Date _____