CARDIOVASCULAR SURGERY ASSOCIATES
PATIENT HISTORY FORM

DATE:_____

PATIENT NAME:_____ DOB:_____ AGE:_____

1. What is your chief complaint related to this visit?_____
_____

2. How and when did this problem start?_____
_____

3. Height:_____ Weight:_____

4. Have you ever experienced or are you currently experiencing any of the following?

_____episodes of blindness or blurred vision
_____chest pain
_____pain down the arm
_____coughing up blood
_____shortness of breath
_____stomach ulcers
_____swelling in arms / legs
_____unusual weight loss / gain
_____non-healing sores of feet / toes
_____discolored feet / toes

5. Have you ever had any of the following?

_____cervical or lumbar disc herniation
_____spine or head injury
_____stroke or TIA
_____heart attack or angina
_____high blood pressure
_____ cancer, leukemia or lymphoma
_____epilepsy or seizure
_____headaches – tension / migraine / cluster
_____diabetes / anemia / B12 deficiency
_____tuberculosis
_____rheumatic fever
_____Other:_____

6. Surgical history – Please list any previous operations you have had

TYPE OF SURGERY YEAR DONE

1._____

2._____

3._____

4._____

5._____

6._____

7. Habits

Habit	Quantity	How Often	Have you Quit	When did you quit?
Alcohol				
Smoking				
Caffeine				
Other:				

PATIENT NAME:_____ DOB:_____

8. Patients Family History:

	Health – if living	Age of Death	Cause of Death
Father			
Mother			

Number of brothers:_____ Number still living:_____
Number of sisters:_____ Number still living:_____
Number of children:_____ Number still living:_____ List ages:_____

Serious illnesses of children:_____

Do you have any blood relatives who has or has had any of the following? (give relationship)
_____cancer_____
_____heart disease_____
_____high blood pressure_____
_____stroke_____
_____diabetes_____
_____bleeding tendency_____

DRUG ALLERGIES:

DO YOU HAVE ANY DRUG ALLERGIES? _____YES _____NO

PLEASE LIST: REACTION

1._____

2._____

3._____

4._____

Signature:_____ DATE:_____