

# CARDIOVASCULAR ASSOCIATES OF THE PENINSULA

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Marital Status \_\_\_\_\_ No. of Children \_\_\_\_\_ No. of Grandchildren \_\_\_\_\_

### Current Medications:

(Please use back of form if more room needed)

Name: \_\_\_\_\_ Dose: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over the counter medications: \_\_\_\_\_

### Medication Allergies/Intolerances:

Name: \_\_\_\_\_ Reactions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had a dye reaction (x-ray/ contrast dye/iodine allergy)? \_\_\_\_\_

### Major Surgeries/Procedures:

Type & Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical History (Past or Present)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart                      | <input type="checkbox"/> Brain/Nervous System | <input type="checkbox"/> Weight Fluctuations   |
| <input type="checkbox"/> Blood Pressure             | <input type="checkbox"/> Lungs                | <input type="checkbox"/> Bleeding Problems     |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Intestinal           | <input type="checkbox"/> Mobility Difficulties |
| <input type="checkbox"/> Cholesterol                | <input type="checkbox"/> Kidney/Urinary Tract | <input type="checkbox"/> Memory Problem        |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Emotional/"Nerves"    |
| <input type="checkbox"/> Blocked Arteries/Aneurysms | <input type="checkbox"/> Hormonal RX          | <input type="checkbox"/> Vision/Hearing        |
| <input type="checkbox"/> Headaches/Migraine         | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Sexual Difficulty     |

### Heart Tests (place and date):

Cholesterol/Blood Tests \_\_\_\_\_  
Treadmill \_\_\_\_\_  
Echo \_\_\_\_\_  
Rhythm Monitors \_\_\_\_\_  
Angiogram \_\_\_\_\_  
Previous Cardiologist(s) \_\_\_\_\_

### Family History

Relatives	Relatives
Angina _____	Diabetes _____
Heart Attack _____	Heart Disease _____
Bypass Surgery _____	High Blood Pressure _____
Balloon Angioplasty _____	Stroke _____
Bleeding Disorder _____	Sudden Cardiac Death _____
Cancer _____	Other _____

### Habits

Alcohol: Type \_\_\_\_\_ Amount \_\_\_\_\_  Smoke: Packs Daily \_\_\_\_\_ No. of Years \_\_\_\_\_ Date Quit \_\_\_\_\_  
 Coffee: Cups Daily \_\_\_\_\_ Other Caffeine \_\_\_\_\_  
 Exercise: \_\_\_\_\_ min. \_\_\_\_\_ x/week. Type: \_\_\_\_\_  
 Recreational Drugs: Type \_\_\_\_\_ Amount \_\_\_\_\_