SOUTHERN CARDIOVASCULAR ASSOCIATES, PC

# MEDICAL HISTORY

NAME: _____ DATE: _____

## PREVIOUS MEDICAL ILLNESSES

Have you had any of the following:

- ❑ Asthma
- ❑ Emphysema
- ❑ High Blood Cholesterol
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Heart Attack
- ❑ Heart Condition
- ❑ Increased Blood Pressure
- ❑ Anemia
- ❑ Ulcer Disease
- ❑ Gallbladder Disease
- ❑ Stroke
- ❑ Thyroid Condition
- ❑ Back Injury
- ❑ Arthritis
- ❑ Prior history of Renal Failure
- ❑ Any other condition not listed

## CARDIAC RISK FACTORS

- ❑ Y ❑ N Tobacco Use
- ❑ Y ❑ N 2nd Hand Smoke
- ❑ Y ❑ N Never Smoked
- ❑ Y ❑ N Previous History of Smoking
- ❑ Y ❑ N Non-smoker
- ❑ Y ❑ N FH of Heart Disease F/Bro <55
- ❑ Y ❑ N FH of Heart Disease M/Sis <65
- ❑ Y ❑ N History of PVD
- ❑ Y ❑ N Using Cocaine

_____

❑ None of the above

## PAST SURGICAL HISTORY

Have you ever had any operations? ❑ Yes ❑ No
If so, when, where and for what reason?

## PRESENT MEDICATION

What medicines, if any, are you presently taking?

List if possible: _____

## ALLERGIES

Are you allergic to any medication? ❑ Yes ❑ No

## FAMILY HISTORY

Is there a family history of:

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ High Blood Cholesterol
- ❑ Heart Condition
- ❑ Early Deaths

## SOCIAL HISTORY

❑ Exercise Habits

Do you drink alcohol? ❑ Yes ❑ No

If yes, how many do you consume?