

**HEALTH HISTORY**

**NAME:** \_\_\_\_\_

**Referring Physician with address/phone:**

**Dr.** \_\_\_\_\_

**Reason for appointment:** *(check all that apply)*

- Chest Pain/Angina                       Heart Attack                       High Blood Pressure
- Shortness of Breath                       Abnormal Test                       Congestive Heart failure
- Dizziness/Passing out                       Palpitations                       Pre-op Evaluation
- Heart Murmur/Valve Problem                       Cardiac arrest                       Stent/Angioplasty
- Heart Surgery/CABG/Valve Surgery                       Pain in Legs with Walking/Claudication

**Other illness:**

- Diabetes                       High Cholesterol                       Heart Attack                       Emphysema/COPD
- Kidney Problems                       Stomach Problems/Ulcers                       Pneumonia                       Stroke/CVA/TIA

**Allergies** (list medications & reactions):

**Allergy to iodine contrast?**  Yes  No

**Latex?**  Yes  No

**Current medications:** (Please include name, dose and frequency)

Name	Dose	Frequency

**Do you take aspirin daily?**

**Smoking:**

Never                       Quit \_\_\_\_ Year?                       Current Smoker :  Packs a day for \_\_\_\_ yrs.

**Alcohol use (How often):**

**Family history of cardiac disease or stroke:**

**Please list any recent heart tests such as stress tests or echocardiograms (include date and location):**

**Please list all surgeries or procedures (include hospital and date):**

**Heart By-Pass/CABG/Valve Surgery/Pacemaker:**

	Hospital	Date

**Angiogram or Angioplasty:**

	Hospital	Date