Heart of Texas Cardiology, P.A.
(512) 474-5551 Fax (512) 474-7324

Acct # ____________

PATIENT PERSONAL HISTORY

DATE ____________

PATIENT'S NAME ____________ DATE OF BIRTH ____________
AGE ____________
REFERRING PHYSICIAN/PERSON ____________
BRIEF DESCRIPTION OF PRESENT ILLNESS:
(REASON(S) FOR APPOINTMENT)

FOR DOCTOR ONLY:

NEW PT PAGE 1 (6-02)

PATIENT: WRITE ON THIS SIDE ONLY

Name: ______________________________ DOB: ______

CIRCLE ONE: (YES OR NO)

DOCTOR ONLY

DO **YOU** HAVE A HISTORY OF:

PAST MEDICAL HISTORY

Y	N	High blood pressure
Y	N	Diabetes
Y	N	High cholesterol or triglycerides
Y	N	Smoker: Started ____________
		Pack(s) per day: ____________
		Stopped: ________________
Y	N	Family history of heart problems
Y	N	Kidney Problems
Y	N	Gout

DO **YOU** HAVE A HISTORY OF:

CARDIAC HISTORY:

Y	N	Rheumatic fever or scarlet fever
Y	N	Heart murmur
Y	N	Heart rhythm problems
Y	N	Fainting spells, dizzy spells Or passing out
Y	N	Shortness of breath
Y	N	Strokes
Y	N	Heart failure
Y	N	Heart bypass surgery

HAVE **YOU** EVER HAD A:

PAST CARDIAC EVALUATION:

Y	N	Treadmill exercise test
Y	N	Echocardiolgram
Y	N	Heart Catheterization (angiogram)
Y	N	Nuclear Stress Test

DO **YOU** HAVE A HISTORY OF:

VASCULAR HISTORY:

Y	N	Pain in legs with walking
Y	N	Surgery on neck blood vessels (carotid endarterectomy)
Y	N	Surgery on blood vessels in legs
Y	N	Aortic aneurysm
Y	N	Blood clots in legs

PATIENT: WRITE ON THIS SIDE ONLY

NAME: ______________________________ **DOB:** _________

DO **YOU** HAVE A HISTORY OF:

DOCTOR ONLY

GENERAL MEDICAL HISTORY:

Y	N	Stomach ulcers	______________________
Y	N	Hiatal Hernia	
Y	N	Gallbladder disease	______________________
Y	N	Hepatitis	
Y	N	Pancreatitis	______________________
Y	N	Prostate problems	
Y	N	Emphysema (COPD)	______________________
Y	N	Asthma	
Y	N	Pulmonary Embolus (blood clot to lung)	______________________
Y	N	Pneumonia	
Y	N	Tuberculosis	______________________
Y	N	Cancer	
Y	N	Seizures	______________________
Y	N	Bleeding problems	
Y	N	Thyroid problems	______________________
Y	N	Headaches	
Y	N	Arthritis	______________________
Y	N	Back problems	

BLOOD BORN INFECTIONS:

Y	N	Transfusions	______________________
Y	N	Past use of street drugs	
Y	N	Hemophiliac	
Y	N	Are you HIV positive?	______________________

SURGERIES OR HOSPITALIZATIONS:

	YEAR	PROCEDURE	HOSPITAL
1			
2			
3			
4			
5			
6			

NEW PT PAGE 3 (6-04)

NAME: ______________________________ **DOB:** ______

MEDICATIONS:

____

____

____

____

____

ALLERGIES: MEDICATION(S) TYPE OF REACTION

____

____

____

HAVE YOU HAD AN ADVERSE REACTION OT X-RAY DYE? YES NO

FAMILY HISTORY: ____

____

____

SOCIAL HISTORY: _____ Married _____ Single _____ Widow(er)

Occupation: ______________________________ Retired: ______________________

Coffee/caffeine intake cups/day ____________________ Alcohol use: ____________________

Diet followed: ____

____

ROS: (Physician)

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