Heart of Texas Cardiology, P.A.

(512) 474-5551 Fax (512) 474-7324

Date: _____

Patient Personal History

Name: _____ Age: _____ Date of Birth: _____

Referring Physician: _____

Brief description of present illness (reason(s) for appointment):

_____

_____

_____

Tell us about your Symptoms:

_____

_____

_____

Do you have any of these:

		Describe
Y N	Chest Pain	_____
Y N	Leg pain when walking	_____
Y N	Dizziness	_____
Y N	Shortness of Breath	_____
Y N	Swelling in the legs	_____
Y N	Fatigue or weakness	_____
Y N	Heart Palpitations	_____
Y N	Fainting	_____
Y N	Weight Gain	_____
Y N	Wheezing	_____

CIRCLE ONE: (YES OR NO)

DO YOU HAVE A HISTORY OF RISK FACTORS FOR HEART DISEASE

Y N High blood pressure
Y N Diabetes
Y N High cholesterol or triglycerides
Y N Smoker: Started:_____
Packs per day: _____
Stopped: _____
Y N Family history of heart problems

DO YOU HAVE A HISTORY OF CARDIAC Disease

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
Y N Angioplasty

HAVE YOU EVER HAD PAST CARDIAC EVALUATION

Y N Treadmill exercise test
Y N Echocardiogram (ultrasound)
Y N Heart Catheterization (angiogram)
Y N Nuclear medicine stress test
Y N EKG (electrocardiogram)

DO YOU HAVE A HISTORY OF Blood Vessel Disease:

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

Elaborate if you can

PAST 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
Y	N	HIV or AIDS

Elaborate if you can

SURGERIES OR HOSPITALIZATIONS:

	Year	Hospital	Procedure
1.			
2.			
3.			
4.			
5.			
6.			

MEDICATIONS:
Name: Dosage Frequency

ALLERGIES:
MEDICATION TYPE OF REACTION

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

FAMILY MEDICAL HISTORY:

SOCIAL HISTORY: _____Married _____Single _____Widow(er)

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

Diet followed_____

Exercise Program? _____

OTHER HEALTH PROBLEMS: _____