Heart of Texas Cardiology
(512) 474-5551 Fax: (512) 474-7324

Date: _____

Patient Personal History:

Name: _____ Age: _____ DOB: _____

Phone Number: _____ Pharmacy phone number: _____

Referring Physician: _____ Primary Care Physician: _____

Reason for your 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 legs	_____
Y N	Fatigue or weakness	_____
Y N	Heart Palpitations	_____
Y N	Fainting	_____
Y N	Weight gain	_____
Y N	Wheezing	_____
Y N	Hypertension	_____

Please tell us your medical history:

		Explain
Y N	Cancer	
Y N	Skin disease	
Y N	ENT problems	
Y N	Cardiovascular Disease	
Y N	Rheumatic fever	
Y N	Murmur	
Y N	Rhythm problems	
Y N	Stroke	
Y N	Heart failure	
Y N	Heart catherization	
Y N	Stent	
Y N	Heart Surgery	
Y N	Prior cardiac testing	
Y N	GI problems	
Y N	Urology problems	
Y N	Neurology problems	
Y N	Blood diseases	
Y N	Psychiatric disorders	
Y N	Anemia	

Surgeries or hospitalizations:

Year	Hospital	Reason/Procedure

Medications: (continue on back for additional space)

Name:	Dosage	Frequency

Allergies:

Medication Type of reaction

_____

_____

_____

_____

Have you had an adverse reaction to x-ray dye? ____Y ____ N Type of reaction: _____

Family medical history:

_____

_____

_____

_____

Social history:

Marital Status: _____ Married _____ Single _____ Widow(er) _____ Partner ____Divorced

Children: _____ Y _____ N Ages: _____

Smoker/tobacco: ___ Y ___ N Quit/when: _____ Frequency/ pk per day: _____

Alcohol use: _____ Y _____ N Type: _____Frequency: _____

History of "street drug" usage: _____ Y _____ N Type: _____Frequency: _____

Coffee/caffeine: _____ Y _____ N Frequency: _____

Level of education: _____ Occupation: _____ F/T: ___ P/T: ___ Disabled: ___

Diet followed: _____ Exercise program: _____

Other health problems:

_____

_____