CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS

Patient Medical History Information

Patient Name: _____ Date of Birth: _____

Primary Physician: _____ Referring Physician: _____

Reason for Referral: _____

Who do you live with: _____

Please list any spouse/family members or others who will be involved in your care: (names and contact info)

_____

Social History

Do you smoke? [] yes [] no [] quit If yes, for how long? _____ how many packs per day? ____

Are you a former smoker? _____ If you quit, how long ago? _____ how many packs per day? _____

Do you drink alcohol? [] yes [] no [] quit If yes, how many drinks per day? _____

If you quit, how long ago? _____

Do you have a history of substance abuse or IV drug use? _____

Have you completed a "Durable Power of Attorney for Healthcare" also known as an "Advanced Directive" or a "Living Will"? [] yes [] no -if yes, please provide our office with a copy for your medical records.

Do you have difficulty with any of the following?

[ ] Hearing [ ] Seeing [ ] Concentrating [ ] Remembering [ ] Making Decisions
[ ] Climbing Stairs [ ] Dressing [ ] Bathing [ ] Doing errands alone

Family History

Mother: [] Living [] Deceased If deceased, at what age? _____ Cause of death? _____

Father: [] Living [] Deceased If deceased, at what age? _____ Cause of death? _____

Brothers: Number living: ___ Number Deceased: ___ if deceased, at what age? _____Cause? _____

Sisters: Number living: ___ Number Deceased: ___ if deceased, at what age? _____ Cause? _____

Children: Number living: ___ Number Deceased: ___ if deceased, at what age? ____ Cause? _____

Check any conditions/diseases which your father, mother, brothers, sisters, or children have experienced:

[] bleeding disorders [] cancer [] coronary artery disease [] diabetes [] heart attack [] heart problems
[] high cholesterol [] hypertension [] kidney disease [] pulmonary disease [] seizures/epilepsy
[] stroke [] sudden cardiac death [] tuberculosis [] varicose veins Other: _____

Medical History -- Please check all serious medical conditions for which you have been treated.

[] Aortic Aneurysm [] Aortic Valve Disorder [] Arrhythmia [] Asthma [] **Cancer*** [] Cardiomyopathy
[] Congenital Heart Disease [] Congestive Heart Failure [] COPD [] Coronary Artery Disease [] CVA
[] Depression [] Deep Vein Thrombosis [] **Diabetes**** [] Gastrointestinal disease [] Genitourinary disease
[] Headaches/Migraines [] Heart Attack [] Hematologic disease [] Hyperlipidemia [] Hypertension
[] Kidney disease [] Liver disease [] Mitral Valve Disorder [] Neurologic disorder [] Pacemaker
[] Peripheral Arterial Disease [] Stroke [] Thyroid Problems [] Warfarin (Coumadin) Management

*** If history of Cancer, please give details** _____

** **If Diabetic,** controlled by: _____ insulin ____other medication ____diet

Other: _____

Surgical History Please list all operations below, and significant complications related to the operations:

Operation:	Date:	Significant Complication:

Review of Symptoms — Please circle any conditions or symptoms you are currently experiencing, or have recently experienced

Constitutional: Fever, night sweats, weight change (+/- ____ lbs), exercise intolerance
Eyes: Dry eyes, irritation, vision changes
Ears: Difficulty hearing, ear pain
Nose: Frequent nosebleeds, nose/sinus problems, runny nose, sinus pressure
Mouth/Throat: Sore throat, bleeding gums, snoring, dry mouth, oral abnormalities, mouth ulcer, Teeth abnormalities, mouth breathing
Cardiovascular: Chest pain, chest pain on exertion, arm pain on exertion, light headed on standing, shortness of breath when walking, shortness of breath when lying down, palpitations, heart murmur,
Respiratory: Cough, wheezing, shortness of breath, coughing up blood, sleep apnea
Gastrointestinal: Abdominal pain, vomiting, change in appetite, black stools, frequent diarrhea
Genitourinary: Urinary loss of control, difficulty urinating, increased urinary frequency, hematuria incomplete emptying
Musculoskeletal: Muscle aches, muscle weakness, arthritis/joint pain, back pain, swelling in the extremities
Skin: Jaundice, rash, hives, itching, dry skin, growth/lesions
Neurologic: Loss of Consciousness, weakness, numbness, seizures, dizziness, migraines, frequent or severe headaches, restless legs
Psychiatric: Depression, sleep disturbances, restless sleep, alcohol abuse,
Endocrine: Fatigue, increased thirst, hair loss, increased hair growth, cold intolerance,

Other: _____

MEDICATION INFORMATION SHEET

Name: ____ Date:_______________ Diabetic: Yes ____ No ____

Allergies:____ Date of Birth:_________________

Pharmacy: ____

--Please list **Name and Address** of your Preferred Pharmacy. Thank you

			*** FOR INTERNAL OFFICE USE ONLY ***					
Medications	**Dose**	**Frequency**						