

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 addresses)

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.

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: _____

Diagnostic Tests —List any recent diagnostic tests, including angiograms, ultrasounds, or x-rays:

Name of test/xray: _____

Date: _____

Where Performed: _____

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:

<u>Operation:</u>	<u>Date:</u>	<u>Significant Complication:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____

