

**INTERVENTIONAL CARDIOLOGISTS OF GAINESVILLE  
PATIENT MEDICAL HISTORY FORM**

**NAME:** \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

**CARDIAC HISTORY**

Heart Attack	Yes	No
Angina	Yes	No
Passing Out Spells	Yes	No
Arrhythmias	Yes	No
Hear Murmur	Yes	No
Holter / Event Monitor	Yes	No
Stress Test	Yes	No
Echocardiogram	Yes	No
Catheterization	Yes	No
Pacemaker/Defibrillator	Yes	No
Angioplasty	Yes	No
Coronary Stents	Yes	No
Heart Surgery	Yes	No
Shortness of Breath	Yes	No
Other:	_____	

**VASCULAR HISTORY**

Stroke /Mini Stroke	Yes	No
Aneurysm	Yes	No
Carotid Surgery	Yes	No
Carotid Stent	Yes	No
Kidney Blockage	Yes	No
Kidney Stent	Yes	No
Leg Blockage	Yes	No
Leg Angioplasty/Stent	Yes	No
Leg Bypass	Yes	No
Other:	_____	

**VASCULAR RISK FACTORS**

High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Diabetes	Yes	No
Tobacco Use	Yes	No
Family Members with Heart Disease	Yes	No

**MEDICAL HISTORY**

Surgeries

_____	_____
_____	_____
_____	_____
_____	_____

Other Illnesses

_____	_____
_____	_____
_____	_____

**ALLERGIES**

<u>Medication</u>	<u>Reaction</u>
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_____	_____
_____	_____
_____	_____
_____	_____

**MEDICATIONS**

Name of Drug	mg	Per Day
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Name of Drug	mg	Per Day
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SOCIAL HISTORY**

Marital Status \_\_\_\_\_  
 Children: Yes No How Many? \_\_\_\_\_

Alcohol Use: \_\_\_\_\_  
 Occupation: \_\_\_\_\_