

**Interventional Cardiologists of Gainesville**  
**Patient Medical History Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS**

Name of Drug	mg	Per Day
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

<b>Cardiac History</b>	Yes	No
Heart Attack		
Angina		
Passing out Spells		
Arrhythmias		
Heart Murmur		
Holter/Event Monitor		
Stress Test		
Echocardiogram		
Catheterization		
Pacemaker/Defibrillator		
Shortness of Breath		
Vascular History		
Stroke/Mini Stroke		
Carotid Stent/Surgery		
Kidney Stent/Surgery		
Leg Stent/Surgery		
Vascular Risk Factors		
High Blood Pressure		
High Cholesterol		
Diabetes		
Tobacco Use		
Alcohol Use		
Family member with heart disease		

**Medical History**

Surgeries	Date
_____	_____
_____	_____
_____	_____
_____	_____

**Other Illnesses**

_____
_____
_____
_____

**Allergies**

_____
_____
_____
_____