CardioVascular Institute of Scottsdale
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HEALTH HISTORY FORM

Please complete this form before your first visit. You can type into it on your computer before printing it.
Bring it with your Patient Information Form, your insurance card and a photo ID.

ABOUT YOUR VISIT

Last name _____ First name _____ Date of birth _____ Today's date _____

Main reason for your visit _____

CURRENT MEDICATIONS

Include over-the-counter medicines, aspirin, vitamins and supplements.

☐ I do not take any medications *You may also bring your medication bottles or a printed list.*

Medication	Dose (for example, 10 mg)	How often (for example, once a day)

ALLERGIES

☐ No known allergies Are you allergic to X-ray contrast dye (iodine)? ☐ Yes ☐ No Latex? ☐ Yes ☐ No

Medication, food or other allergy	What happened (rash, hives, swelling, trouble breathing)

HEALTH HISTORY

Patient name _____ Date of birth _____

MEDICAL HISTORY *Check any condition you have now or have had in the past.*

Heart and blood vessels

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Heart failure
- ☐ Cardiomyopathy
- ☐ Atrial fibrillation or flutter
- ☐ Other heart rhythm problem
- ☐ Valve disease or mitral valve prolapse
- ☐ Heart murmur
- ☐ Congenital heart disease
- ☐ Heart transplant
- ☐ Stroke or TIA (mini-stroke)
- ☐ Carotid artery disease
- ☐ Aortic aneurysm
- ☐ Peripheral artery disease (PAD)
- ☐ Blood clot in a leg or lung (DVT or PE)
- ☐ Varicose veins

Other conditions

- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Sleep apnea
- ☐ Asthma
- ☐ COPD or emphysema
- ☐ Reflux (GERD)
- ☐ Hiatal hernia
- ☐ Anemia
- ☐ Bleeding or clotting disorder
- ☐ Cancer, type: _____

Other conditions not listed above

_____

_____

HEART AND VASCULAR PROCEDURES *Check any you have had and write the year.*

- ☐ Heart catheterization Year _____
- ☐ Coronary stent Year _____
- ☐ Bypass surgery (CABG) Year _____
- ☐ Pacemaker Year _____
- ☐ Defibrillator (ICD) Year _____
- ☐ Ablation for heart rhythm Year _____
- ☐ Valve repair or replacement Year _____
- ☐ Leg artery stent or bypass Year _____
- ☐ Varicose vein procedure Year _____

Other surgeries ☐ None

Surgery	Year

FAMILY HISTORY *Parents, brothers, sisters and children only.*

Mother: ☐ Living ☐ Deceased Age now or age at death _____ Cause of death _____

Father: ☐ Living ☐ Deceased Age now or age at death _____ Cause of death _____

Check any condition in your family and write who (for example, father, sister).

- ☐ Heart attack, stent or bypass before age 55 in a man or 65 in a woman Who _____
- ☐ Sudden cardiac death, or unexplained death before age 50 Who _____
- ☐ Cardiomyopathy or heart failure Who _____
- ☐ Aortic aneurysm Who _____
- ☐ High cholesterol Who _____
- ☐ Abnormal heart rhythm or pacemaker Who _____
- ☐ Stroke Who _____
- ☐ Diabetes Who _____

HEALTH HISTORY

Patient name _____ Date of birth _____

SOCIAL HISTORY

Tobacco or nicotine: ☐ Never ☐ Current ☐ Former, year quit _____ Packs or amount per day _____

Type: ☐ Cigarettes ☐ Cigars ☐ Chewing tobacco ☐ Vaping or e-cigarettes Years used _____

Alcohol: ☐ None ☐ Yes, drinks per week _____ ☐ Former drinker, sober since _____

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy drinks Servings per day _____

Recreational drugs: ☐ Never ☐ Current ☐ Former Which ones (including marijuana) and how often _____

Exercise: Days per week _____ Type of exercise _____

Occupation: Current or former work _____

REVIEW OF SYMPTOMS

Check any symptom you have had in the past 3 months.

☐ **I have none of the symptoms below**

General
- ☐ Fever or chills
- ☐ Fatigue or weakness
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Change in appetite

Eyes, ears, nose and throat
- ☐ Blurred or lost vision
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Nosebleeds

Lungs and breathing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Snoring or breathing pauses in sleep

Skin
- ☐ Rash or itching
- ☐ Change in skin color

Heart
- ☐ Chest pain or pressure at rest
- ☐ Chest pain or pressure with activity
- ☐ Short of breath at rest
- ☐ Short of breath with activity
- ☐ Trouble breathing when lying flat
- ☐ Waking up at night short of breath
- ☐ Racing, pounding or skipped heartbeats
- ☐ Dizziness or lightheadedness
- ☐ Fainting or nearly fainting
- ☐ Swelling in the legs or ankles

Circulation
- ☐ Leg pain when walking that eases with rest
- ☐ Cold hands or feet
- ☐ Color change in fingers or toes
- ☐ Sores on the legs or feet that do not heal

Stomach and digestion
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Vomiting blood
- ☐ Blood in stool or black stool
- ☐ Heartburn
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Diarrhea

Blood
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Recent blood transfusion
- ☐ Swollen glands

Muscles and joints
- ☐ Joint pain, stiffness or swelling
- ☐ Muscle aches
- ☐ Leg cramps

Nervous system
- ☐ Numbness or tingling
- ☐ Weakness on one side
- ☐ Balance or walking problems
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremor

The information on this form is correct to the best of my knowledge.

_____ Date _____

Signature of patient or legal representative

OFFICE USE ONLY

Reviewed with patient by: _____ Date: _____ Entered in chart: ☐ Yes ☐ No