Print in Color or Grayscale Only

Using Adobe Acrobat Reader 8.0 or later

Initial Health History

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME **Marking Instructions** Please use a # 2 pencil PLEASE PRINT PATIENT'S FIRST NAME PATIENT'S DATE OF BIRTH Fill in the complete oval as shown... Month Day Year PATIENT MEDICAL HISTORY Please indicate if **YOU** have a history of any of the following. Mark all that apply. If none, mark "NONE." Abnormal heart rhythm or EKG **Kidney disease** Anxiety Leg circulation problem Arthritis Liver disease Asthma Lung disease Blood clots **Prostate disease** Blood disease **Psychiatric disease** Cancer (any kind) **Rheumatic fever** Congestive heart failure Sleep apnea Convulsions or epilepsy Stomach ulcers Depression Stroke Diabetes AIT C Emphysema Thyroid disease Heart attack **Tuberculosis** Heart murmur Valvular heart disease Heart valve disease Varicose veins Hepatitis Vascular disease Other High blood pressure High cholesterol or triglycerides **NONE** SURGICAL HISTORY Please indicate if **YOU** have a history of any of the following surgeries. Mark all that apply. If none, mark "NONE." Aneurysm repair Heart valve surgery Aortic aneurysm Hernia repair Hysterectomy Appendectomy Bariatric surgery **Organ transplant** Blood vessel surgery Orthopedic surgery Breast surgery Ovaries removed Cataract surgery Pacemaker implant Carotid surgery Plastic surgery Coronary surgery **Prostate surgery** Defibrillator implant Vascular surgery Gallbladder surgery Other **NONE** Heart angioplasty / stent **PATIENT STATUS** Please indicate **YOUR** current living situation. Living alone Living with spouse / significant other Living with family / friends Living in an assisted living facility



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Please indicate which family member(s) have had these illnesses. Mark all that apply. If none, mark "NONE."

FAMILY HISTORY UNKNOWN

	Father	Mother	Sibling	NONE
Abnormal heart rhythm				
Congenital heart disease				
Diabetes				
Heart disease				
Stroke				
Sudden death				
Valve disease				
None of the above illnesses				

○ Mo	other, grandmothe	er, or sister	developed	heart disea	se before t	he age	of 65
C Fat	her, grandfather,	or brother	developed	heart disea	se before t	he age	of 55

TOBACCO USE						
How would you des	cribe vour cigarett	e smoking?				
-	irrent (every day)	•	current (some day	s) oprev	vious 🔾 no	ever 🔘
If you are a FORMEI			(,	.,		
•	·	w	ithin the last mont	th 🔘	more than 1 year	ago 🔘
How many packs pe	er day do you (or di					
	never 🔾	less than 1	1.	-2 🔾	2-3	3-4
Smoking cessation:						
		_	not applicable		to quit now / need	
			et ready to quit 🤇		do not want to	•
Are you exposed to	passive (second na	ana) smoke?			yes O	no 🔾
ALCOHOL USE						
How often do you c	onsume alcohol?					
	never		rarely 🔘	sometimes	freque	ently 🔘
Number of drinks:	1-2		3-4			7+ 🔾
Frequency:			monthly 🔾	weekly		daily 🔘
DRUG USE						
none	curre	ntly 🔘	previously C	prefer t	o discuss with physi	cian 🔾
HABITS						
Type(s) of caffeine:	n	one 🔾	coffee C	tea	o soft dr	inks 🔘
Number of caffeine		<u> </u>			00.00.	
	/-		occasionally (1-2		3-4
			5-6	7+	n	one 🔘
Exercise - Type(s) of	exercise:					
			bicycling \subset			ning 🔘
		_	swimming C	aerobics	<u> </u>	ther 🔘
Number of times yo	ou exercise per wee	ek:				
			occasionally C			3-4
			5-6 🤇	<i>)</i> 7+	n	ione 🔘