Cardiothoracic & Vascular Surgical Associates, S.C.
Confidential Health History

Name of Patient: _____ DOB _____

Have you ever had any of the following (circle all that apply)

Aneurysm
Where: _____
Alcoholism
Anemia
Asthma
Bleeding Disorder
Blood Transfusion
Bronchitis
Cancer
Where: _____
Cataracts
COPD
Diabetes
Drug Dependency
DVT/Blood Clot
Emphysema
Epilepsy / Seizures
Esophageal Reflux
GERD
Glaucoma
Gout
Heart Attack
Heart Rhythm problem
Heart Valve Disorder
Hepatitis—what kind?_____
Hernia
HIV Positive
High Cholesterol
High Blood Pressure
Kidney Disease
Kidney dialysis *
Liver Disease
Pacemaker
Phlebitis
Pneumonia
PVD/Circulation problem
Rheumatic Fever
Stroke
Thyroid Disease
Tuberculosis
Ulcers
Varicose Veins
OTHER: _____
_____
_____
NONE

***Dialysis M T W T F S Dialysis Center** _____**Nephrologist**_____

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all medications and supplements you take regularly (If you brought in a list, we will copy it instead of filling in this section)

Medication	Dose	Frequency (how often)	Prescribing Physician (or state if over the counter)

Please list all medication allergies and the reaction you have if you take them

Allergic To:	Reaction	Allergic To:	Reaction

Family History

Has any blood relative had any of the following? Circle the problem and indicate which relative: for example, "maternal grandmother"

Problem	Family Member	Problem	Family Member
Aneurysm – what kind?		High Cholesterol	
		High Blood Pressure	
Cancer—what kind?		Kidney Disease	
		Stroke	
Heart disease—what kind?		OTHER	

Social History

Marital status: Single Married Divorced Widowed

Retired? Yes No What is your current occupation? _____

Do you smoke? Never Quit—when?_____Yes—how much per day? _____

Do you drink alcohol? Never Former Yes—how much and how often? _____

Do you use illegal drugs? Never Former Yes—what kind, how much and how often? _____

Cardiothoracic & Vascular Surgical Associates,S.C.
Please fill out both pages of this form

Date: _____

Name of Patient: _____

DOB: _____/_____/_____ Age: _____ Height: _____ Weight: _____

Have you ever been seen by one of our physicians? Yes / No Whom? _____ Approximate Date? _____

Reason for visit: _____

Referring Physician: _____

Primary Care Physician: _____

REVIEW OF SYSTEMS

Do You Have Now or Have You Had Recently (circle all that apply)

GENERAL
Fever
Chills
Weight loss
Sweats

EYES
Blurred vision
Double vision
Vision changes

HEAD, EARS, NOSE, THROAT
Headaches
Bleeding gums
Nosebleeds
Sore throat

CARDIOVASCULAR
Chest pain
Irregular heart beat
Rapid heart beat
Palpitations
Swelling of ankles
Varicose veins
Difficulty breathing on exertion
Dizziness
Blackouts/Fainting

RESPIRATORY
Shortness of breath
Wheezing
Chronic cough
Snoring
Coughing up Blood

GASTROINTESTINAL
Difficulty swallowing
Poor appetite
Stomach pain
Nausea
Vomiting
Constipation
Diarrhea

GENITO-URINARY
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

NEUROLOGICAL
Memory difficulties
Tingling or numbness
Tremors
Generalized weakness

MUSCLES/JOINTS
Joint pain
Joint swelling
Muscle cramps

SKIN
Bruise easily
Hives
Change in moles
Rash
Sore that won't heal

PSYCHIATRIC
Anxiety/Nervousness
Depression
Difficulty sleeping

BREAST
Lumps
Tenderness
Swelling
Nipple Discharge

ENDOCRINE
Constipation
Weight gain
Weight loss
Loss of hair

For Office Use Only

Office Notes

HPI: _____

Current Testing:

VS / PE:
BLOOD PRESSURE _____