



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**CARDIOLOGY MEDICAL HISTORY**

Chief Complaint: (reason why you are here) \_\_\_\_\_

Medical History: (include date, if known)

- Heart Attack \_\_\_\_\_
- Chest Pain \_\_\_\_\_
- Coronary Artery Disease \_\_\_\_\_
- Heart Failure \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Peripheral vascular surgery \_\_\_\_\_
- High cholesterol \_\_\_\_\_
- Stroke or TIA \_\_\_\_\_
- Heart Murmur \_\_\_\_\_
- Abnormal heart rhythm or heart beat \_\_\_\_\_
- Asthma \_\_\_\_\_
- COPD/Emphysema \_\_\_\_\_
- Bleeding disorders \_\_\_\_\_
- Abnormal clotting \_\_\_\_\_
- Ulcers \_\_\_\_\_
- Deep vein thrombosis \_\_\_\_\_
- Peripheral vascular disease \_\_\_\_\_
- Kidney disease \_\_\_\_\_
- Cancer, what type \_\_\_\_\_

- Hepatitis \_\_\_\_\_
- Thyroid Disease \_\_\_\_\_
- Coronary bypass surgery \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Cardiac Cath \_\_\_\_\_  
 with stent \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- ICD (defibrillator) \_\_\_\_\_
- Treadmill stress test \_\_\_\_\_
- Nuclear stress test \_\_\_\_\_
- Echocardiogram \_\_\_\_\_
- Stress Echocardiogram \_\_\_\_\_
- List all other surgeries or procedures:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICATIONS including the name, dose, how often you take each one. (Continue on back if needed)

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

Supplements, over-the-counter vitamins, etc.

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

Have you ever had an allergic reaction to or side effects from medication?  Yes  No

If Yes, please list the medication and the reaction you had \_\_\_\_\_

Have you ever had an allergic reaction to intravenous dye, iodine, shellfish or food:  Yes  No

If Yes, please explain: \_\_\_\_\_