HEART RHYTHM & VASCULAR
Specialists of Dayton

MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Please check which of the following conditions you personally have been diagnosed with or any symptoms you currently have

Cardiac/Vascular

___Coronary Artery Disease
___Cardiac Arrest
___Chest Pain
___Aortic Stenosis
___Embolism
___Heart Attack (when)
___Pericarditis
___Sinus Arrhythmia
___Atrial Flutter (A-flutter)
___Extra or skipped beats
___Hyperlipidemia
___Carotid Artery Disease (Neck Arteries)
___TIA (mini Stroke)
___DVT – (Blood Clot in Arm or Leg)
___Raynaud's Disease
___Renal Artery Stenosis (blockage in kidney arteries)
___Subclavian Stenosis
___Thrombophlebitis
___Congestive Heart Failure
___Cardiomegaly
___Abnormal EKG
___Palpitations
___Heart Murmur
___Pericardial Effusion
___Rheumatic Heart Disease
___Atrial Fibrillation (A-fib)
___PVCs
___Valvular heart Disease
___Aneurysm
___CVA (stroke)
___Weak Pulses in your feet or wrists
___PVD/PAD (blockages in your veins or arteries)
___Varicose Veins
___Renal Artery Stenosis
___Thoracic Outlet Syndrome
___Venous Insufficiency

General

___Hypotension (low blood pressure)
___Alzheimer's
___Amaurosis Fugax
___Anxiety Disorder
___Asthma
___Back Pain
___Blood Thinners
___Cancer – Type
___COPD
___Depression
___Diabetes
___Dialysis
___Shortness of breath
___Pulmonary
___Seizure
___Thyroid Disorder
___GERD/ Heartburn
___GI Bleed
___Hemorrhage
___Hypertension (high blood pressure)
___Abdominal Pain
___Liver Disease
___Erectile Dysfunction
___Migraines
___Hepatitis -Type
___Pain in Leg/Arm
___Pleural Effusion
___Lymphedema
___Menopause
___Obesity
___Neuropathy
___Pregnancy
___Kidney
___Snoring
___Sleep Apnea/ CPAP
___Visual
___Fatigue
___HIV

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MEDICAL HISTORY CONT.

Patient Name _____ Date of Birth _____

SOCIAL HISTORY

Alcohol Use: Yes No Previous

If yes, How Often? _____

How Much? _____

How Long?

Recreational Drug Use: Yes No Previous

If yes, Type of drug _____

Frequency _____

Last Use _____

Tobacco Use: Yes No Previous

If yes, Number of packs per day_____

Are you Interested in Quitting? _____

FAMILY HISTORY (LIST WHO)

___Abdominal Aortic Aneurysm

___Bleeding Problems

___Coronary Artery Disease (Heart Attack, Stent, Bypass Surgery)

___Heart Failure

___Diabetes

___Pulmonary (lung) disease

___Sudden Cardiac Death

___Stroke

___Peripheral Vascular Disease

___Cancer

SURGICAL HISTORY

Check the appropriate box(es) if you have had any of the following procedures in the past.

____**NO** Prior or no prior significant surgeries
____ Serious or Advanced reaction to anesthesia
____ Easy Bruising Tendency
____ Easy Bleeding

FEMALES
_____ Breast Surgery
_____ Hysterectomy
_____ Tubal Ligation
_____ Cesarean Section

MALES
_____ Prostate Surgery

GENERAL

___Appendectomy	___Back Surgery	___Lung Surgery
___Gallbladder Surgery	___Hip Replacement	___Tonsil/Adenoids
___Bladder Surgery	___Hernia Repair	___Knee Replacement
___Lithotripsy	___Amputation	___Shoulder Surgery
___Colectomy	___Ileostomy	___Small Bowel Resection

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CARDIOVASCULAR

Please list the Hospital and Year the procedure was performed if known and any other pertinent details

____ Cardiac Catheterization ("Heart Cath") / Coronary Angiogram - _____

____ Coronary Stent (Stent placed in a blocked artery of heart) / PTCA - _____

____ CABG (Heart Bypass Surgery) - _____

____ Heart Valve Repair / Replacement - _____

____ Pacemaker - _____

____ Defibrillator (shock box) _____

____ Abdominal Aortic Aneurysm STENT or Repair _____

____Thoracic Aortic Aneurysm STENT or Repair _____

____ Blood Vessel Repair _____

____ Popliteal aneurysm _____

____ Iliac artery aneurysm _____

____ Carotid Stent (neck artery) _____

____ Carotid Endarterectomy _____

____ Renal (Kidney) Angiogram _____

____ Renal (Kidney) angioplasty and/or stent to kidney artery _____

____ Leg Angiogram or leg stent placement _____

____Leg Bypass _____

____Angiography other location (Specify) _____

____ Vein Stripping (Location - please specify) - _____

____ Vein Ablation (Location - please specify) - _____

____ Other Procedures to the Heart, Arteries or Veins _____

Signature of Patient _____ Date _____