Houston Cardiac Surgery Associates, LLP

CONFIDENTIAL HEALTH HISTORY

Patient Name:____ **Date:**___________________________

Birthdate: ______________________________ **Sex: Male Female Last Physical**_____________

Cardiologist:________________________________ **Referring Doctor:**_________________________________
(If Different)

Briefly explain your reason for seeing the Doctor today:____

____

____

List any allergies you have (including medication allergies):____

____

____

MEDICATIONS: List all medications you are currently taking and the dosage (or attach a list)

____

____

____

Please check symptoms you currently have or have had in the past year.

GENERAL

___Appetite Changes
___Chills
___Weight Changes
___Fever

GASTROINTESTINAL

___Abdominal Pain
___Vomiting
___Constipation
___Diarrhea
___Nausea

EYE,EAR,NOSE

___Difficulty swallowing
___Hoarseness
___Visual Problems

VASCULAR:

___Foot Ulcers
___Leg Pain
___Varicose Veins

MUSCULOSKELETAL

___Back Pain

NEUROLOGIC:

___Fainting
___Headaches
___Numbness
___Weakness

CARDIAC:

___Chest pain
___Heart Disease
___High Blood Pressure
___Shortness of Breath

HEMATOLOGIC:

___Bleed or Bruise easily
___Required a Blood Transfusion

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MEDICAL HISTORY Check the medical conditions you have or have had in the past year.

___Aids	___Chemical Dependency	___Herpes	___Polio
___Alcoholism	___Diabetes	___High Cholesterol	___Prostrate Problem
___Anemia	___Emphysema	___HIV Positive	___Psychiatric Care
___Arthritis	___Epilepsy	___Kidney Disease	___Rheumatic Fever
___Asthma	___Glaucoma	___Liver Disease	___Scarlet Fever
___Bleeding Dis.	___Goiter	___Migraine Headaches	___Stroke
___Breast Lump	___Gout	___Multiple Sclerosis	___Thyroid Problems
___Bronchitis	___Heart Disease	___Pacemaker	___Tuberculosis
___Cancer	___Hepatitis	___Pneumonia	___Ulcers
___Cataracts	___Hernia		

SURGERIES:

Year	Hospital	Reason for Hospitalization

SOCIAL HISTORY: Check which substances you use and **indicate usage per week**.

___Tobacco ___Drugs ___Alcohol

___Pks per day ___Drinks per day

___Years

OCCUPATION:____

FAMILY HISTORY: Fill in health information about your family.

	State of Health	Age at Death	Cause of Death
Father			
Mother			
Brother / Sisters			

PREGNANCY HISTORY:

Year of Birth	Sex of Birth	Complications if any