Heart of Texas Cardiology

Phone (512)474-5551 Fax (512)474-7324

Patient Personal History: **Date:** ____________________

Name: ____ **Age:** __________ **DOB:** _____________

Phone Number: __________________**Pharmacy's name:** _________________**Pharmacy Number**_____________

Referring Physician: ___________________________________ **Phone:** _____________________________________

Primary Care Physician: ________________________________ **Phone:** _____________________________________

Other Physician that will need to be kept update on your cardiac care:

____

Reason for your appointment:

____

____

Tell us about your symptoms:

____

____

____

Do you have any of these:

			Describe
Y	N	Chest Pain	____
Y	N	Leg pain when walking	____
Y	N	Dizziness	____
Y	N	Shortness of breath	____
Y	N	Swelling in leg	____
Y	N	Fatigue or weakness	____
Y	N	Fainting	____
Y	N	Weight gain	____
Y	N	Wheezing	____
Y	N	Hypertension	____

Please tell us your medical history: **Explain**

Y	N	Cancer	____________________
Y	N	Skin disease	____________________
Y	N	ENT problems	____________________
Y	N	Cardiovascular	____________________
Y	N	Rheumatic fever	____________________
Y	N	Murmur	____________________
Y	N	Rhythm problems	____________________
Y	N	Stroke	____________________
Y	N	Heart failure	____________________
Y	N	Stent	____________________
Y	N	Heart Surgery	____________________
Y	N	Prior Cardiac Testing	____________________
Y	N	GI problems	____________________
Y	N	Urology problems	____________________
Y	N	Neurology problems	____________________
Y	N	Blood diseases	____________________
Y	N	Psychiatric disorders	____________________
Y	N	Anemia	____________________

Surgeries or hospitalization:

Year	Hospital	Reason/ Procedure

Medications: (continue on back for additional space)

Name	Dosage	Frequency

Medication Allergies: **Type of reaction:**

____
____
____
____
____

Have you had adverse reaction to x-ray dye? ______ Y _____ N Type of reaction: ______________________________

Family medical history:

____
____
____
____

Social History:

Marital Status: Married ______Single _____ Widow(er) _____ Partner ______Divorced _____

Children: _____ Y _____ N Ages: ____

Smoke/tobacco: ____ Y ____N Quite/when: _______________________ Frequency: ___________________________

Alcohol use: ____ Y ____N Type: __________________________ Frequency: __________________________________

History of "street drugs" ____Y ____N Type: _____________________ Frequency: _____________________________

Coffee/caffeine: ____Y ____N Frequency: ____

Level of education: _____________________ Occupation: _______________ F/T:_____ P/T: _____ Disabled: ______

Diet followed: ________________________________ Exercise program: ______________________________________

Other health problems:

____
____
____