HeartCARE
CENTER OF THE VALLEY

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Allergies

Drug Allergies: _____

Other Allergies _____

Medication List

_____

_____

_____

_____

_____

_____

_____

Family History

Father: _____

Mother: _____

Sister: _____

Brother: _____

Other: _____

Patient Name: _____ Date of Birth: _____

Social History

	Yes	No	Former, year Quit	Quantities	How long
Smoking					
Alcohol					
Drug					

Other: _____

Marital status: _____

Past Surgical History

_____

_____

_____

Past Medical History

Bleeding or clotting disorders: ☐ Yes ☐ No

Cancer: ☐ Yes ☐ No

Chronic Kidney Disease: ☐ Yes ☐ No

Congestive Heart Failure (CHF): ☐ Yes ☐ No

Coronary Artery Disease: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Heart Attack (myocardial infarction): ☐ Yes ☐ No

Heart Valve Disease: ☐ Yes ☐ No

High Blood Pressure (hypertension): ☐ Yes ☐ No

High Cholesterol: ☐ Yes ☐ No

Patient Name: _____ Date of Birth: _____

Lung Disease: ☐ Yes ☐ No

Peripheral Vascular/Arterial Disease (PAD): ☐ Yes ☐ No

Thyroid Disorder: ☐ Yes ☐ No

Stroke: ☐ Yes ☐ No

Other Major Illnesses: ☐ Yes ☐ No, Please Explain:

Review of System

Please circle:

Constitutional	Fever, Weight loss	Other:
Eye	Vision change	Other:
Ear, Nose and Throat	Hearing problem	Other:
Cardiovascular	Chest pain, Shortness of breath, palpitation, Edema	Other:
Respiratory	Shortness of breath, Cough,	Other:
Gastrointestinal	Abdominal pain, Nauseas, Vomiting	Other:
Genitourinary	Difficulty urination	Other:
Musculoskeletal	Muscle pain, Joint pain, Back pain	Other:
Integumentary	Skin rash	Other:
Neurology	Loss of consciousness, Headache, Weakness, Numbness, Dizziness	Other:
Psychological	Anxiety	Other:
Endocrine	Fatigue	Other:
Hematology	Excess bleeding	Other:
Allergic/Immunologic	Hives	Other: