PIMA HEART & VASCULAR

MEDICAL INFORMATION

Name: _____ DOB _____ Age_____ Date: _____
What problem brings you to our office?_____
Who is your Primary Care Physician? _____ Referred by _____
Do you have a Living Will? Yes☐ No☐ Current Occupation _____

Medical/Family History

Do you have any Allergies to medications? Yes☐ No☐ If yes, please list medication and reaction.

_____

_____

Are you allergic to Shellfish or Contrast Dye? Yes☐ No☐
Current Medications, Dosages and Frequency:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Have you been diagnosed with the following?

1. Diabetes Yes☐ No☐ Insulin dependent Yes☐ No☐
2. High Blood Pressure Yes☐ No☐
3. Elevated Cholesterol/Triglycerides Yes☐ No☐
4. Family History with heart disease before age 65? Yes☐ No☐
   If Yes (please select: father, mother, sister or brother)
   Please select: Heart Attack, Stroke, Mini Stroke, Coronary Artery Disease, Carotid Disease
5. List all other Family History: Who/What: _____
   _____
6. Do you have a Pacemaker/ICD/Loop Recorder Implant? Yes☐ No☐ If yes, Device Company Name _____ Date implant _____ Hospital Name _____
7. List Hospitalizations/Surgeries include Year and Hospital name below:
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
8. List all medical problems: _____
   _____

Social History

Have you ever used tobacco? Yes☐ No☐ Type _____
Smoking status? --> Former _____ Date quit _____ Current _____ pack per day _____
Alcoholic beverages? Yes☐ No☐ If yes, number/day _____ number/week _____
Caffeinated beverages? (Soda, tea, coffee, energy drinks, Including decaf) Yes☐ No☐
number/day _____ number/week _____
History of Drug Abuse? Yes☐ No☐ Drug Used _____

Signature_____ Date _____