

# VITAL

HEART & VEIN

## PATIENT MEDICATION / HISTORY FORM

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### Current Medications

List all prescription medications, over-the-counter medications, and vitamins.

Medications / Vitamins	Dosage	Directions

Please list all allergies: \_\_\_\_\_

### Past Medical History:

#### Cardiac

- Arrhythmias
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack
- High Cholesterol
- Hypertension
- Valvular Heart Disease

#### Respiratory

- COPD
- Sleep Apnea (CPAP)

### Past Surgical History:

- Cardiac Cath
- Cardioversion
- Coronary Angioplasty/Stent
- Coronary Artery Bypass
- ICD Placement
- Pacemaker Implant
- RF Ablation
- Heart Valve Repair/Replaced

#### Vascular

- Aortic Aneurysm
- Carotid Disease
- DVT
- Peripheral Vascular Disease
- Varicose Veins

#### EENT

- Diabetes

#### Neurologic

- Seizure Disorder
- Stroke

- Aneurysm Repair
- Appendectomy
- Back Surgery
- Carotid Surgery
- Cholecystectomy (Gallbladder Removed)
- Gastric Bypass
- Hysterectomy
- Kidney Stone treatment

#### Gastrointestinal

- GERD
- Peptic Ulcer Disease

#### Renal / GU

- Renal Failure

#### Hematologic

- Anemia

#### Cancer

- \_\_\_\_\_

- Knee Surgery
- Mastectomy
- Kidney Removed
- Tonsillectomy
- Thyroidectomy
- Other: \_\_\_\_\_

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Pateint Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Family History:

Heart Attack  Yes  No Family Member \_\_\_\_\_  
Stroke  Yes  No Family Member \_\_\_\_\_  
Coronary Bypass Surgery  Yes  No Family Member \_\_\_\_\_  
Diabetes  Yes  No Family Member \_\_\_\_\_  
High Blood Pressure  Yes  No Family Member \_\_\_\_\_  
Coronary Artery Disease  Yes  No Family Member \_\_\_\_\_  
Sudden Death  Yes  No Family Member \_\_\_\_\_  
Other:  Yes  No Family Member \_\_\_\_\_

## Social History:

### Alcohol Use

Do you consume alcohol?  Yes  No How much per day/week? \_\_\_\_\_

### Smoking Tobacco Use

Do you smoke / use tobacco?  Yes  No  Former How much per day/week? \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Primary Care Physician / Other: \_\_\_\_\_

## Pharmacy Information

Pharmacy Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Address: \_\_\_\_\_