

**PERSONAL HISTORY – Cardiology/Endocrinology/Sleep**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Referring Physician \_\_\_\_\_

**Reason for this appointment / description of your symptoms:**

**Past Medical Illnesses** – check any that apply to you

Asthma	Cancer or Tumor	Kidney Stones	Multiple sclerosis	None
Arthritis	Reflux esophagitis	Gallbladder disease	Prostate problems	
Emphysema	Diverticulitis	Lupus (SLE)	Ankylosing Spondylitis	
Blood clot-lung	Stomach Ulcers	Sjogren's syndrome	Thyroid problems	
Blood clot-leg	Crohn's disease	Fibromyalgia	Osteoporosis	
Pulmonary hypertension	Ulcerative colitis	Psoriasis	Diabetes	
Bleeding disorder	Pancreatitis	Rheumatoid arthritis	Sleep Apnea	
Anemia	Kidney disease	Gout		

Any other conditions you see a doctor for \_\_\_\_\_

**Past Cardiovascular Illnesses** – check any that apply to you

High blood pressure	Heart attack	Heart failure	Irregular heartbeat	None
High cholesterol	Heart murmur	Atrial fibrillation	Blood flow problem to legs	
High triglycerides	Stroke	Ventricular tachycardia	Blood flow problem to neck	
Coronary disease				

**Infectious History** - check any that apply to you

Chicken Pox	Measles	Mumps	Hepatitis	Other	None
Rheumatic fever	TB or positive TB test	Scarlet fever			

<b>Other History</b>	Type	Year	Location
Trauma or accident			
Surgeries			
Cardiology Procedures – heart cath, angioplasty			
Cardiology Tests – treadmill, echocardiogram, nuclear scan, MRI			
Electrophysiology Procedures			
Device Implants (pacemakers, defibrillators)			
Peripheral – any surgery, angioplasty, stents to blood vessels (not heart)			
Thyroid Testing			

**Other Testing**

Colonoscopy	Dexa Scan	Pulmonary functions	Sleep Study
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**Family History** Approximate age at diagnosis. Specify if Paternal or Maternal

	Mother	Father	Sibling	Cousin, Aunt, Uncle	Grandparent
Heart disease					
Diabetes					
Congenital deafness					
Sudden cardiac death before age 30					
Aortic aneurysm					
Stroke					
Other					

**Social History**

Do you use Alcohol?  Never  Occasional  Frequently  
 Smoker?  Yes  No  Past How many per day? \_\_\_\_\_  
 Special Diet? \_\_\_\_\_  
 Caffeine use \_\_\_\_\_ How many per day? \_\_\_\_\_  
 Caffeine 4 hours prior to bed at night?  yes  no  
 Exercise?  Routine  Occasional  None  
 Substance Use? \_\_\_\_\_  
 Lifestyle  Married  Single  Widower  Divorced  
 Job description \_\_\_\_\_

**Allergies**

Substance	Reaction	Substance	Reaction

Have you ever had an allergic reaction to x-ray contrast or iodine?

**Medications** (Include prescription, supplements, regular over-the-counter medications)

Name	Dose	Name	Dose

**Preferred Pharmacy** \_\_\_\_\_

**Any Other Comments** \_\_\_\_\_

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