

Illinois Heart and Vascular Medical History

Revised 9.01.06

Name: _____ Sex: M ___ F ___ Birth Date: _____ Date: _____

Primary Care Doctor: _____

Reason for Visit: _____

Allergies: _____

Past Medical History:

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Ulcer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer

Do you have?

	Yes	No	Explain		Yes	No	Explain
Headache			_____	Cough/Wheeze			_____
Dizziness			_____	Passing Out			_____
Visual Problems			_____	Hoarseness			_____
Shortness of Breath			_____	Chest Pain			_____
Palpitations			_____	Feet Swelling			_____
Nausea/Vomiting			_____	Frequent Urination			_____
Flushing/Sweating			_____	Muscle/Joint Pain			_____
Pain Walking			_____	Fever/Chills			_____
Weight Loss			_____	Loss of Appetite			_____

List any previous surgeries or hospitalizations? _____

Social History:

Who do you live with? _____ What type of work? _____

Recreational Activities? _____

Smoke? Yes No (how much?) _____ (how long?) _____

Alcohol? Yes No (how much?) _____ Caffeine? Yes No (how much) _____

Family History: Include Mother/Father/Brothers/Sisters (specify which family member)

High Blood Pressure? _____ Stroke? _____

Heart attack? _____ Heart Disease? _____

Diabetes? _____ Cancer? _____

Medications: _____

If you have any specific request on the dissemination of your medical information please list:

Form Completed by: _____ Date: _____

Reviewed by: (Physician Signature) _____ Date: _____