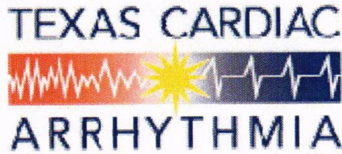


## MEDICAL HISTORY QUESTIONNAIRE

IF IT HAS BEEN THREE OR MORE YEARS SINCE YOUR LAST VISIT, COMPLETE THE ENTIRE FORM

**IF LESS THAN THREE YEARS, PLEASE UPDATE AREAS THAT HAVE CHANGED SINCE THE LAST VISIT**

Patient Name______________________ Appt. Date___________ Date of Birth____________ Age___________

Gender ◯Female ◯Male Primary Care Doctor______________________________________________

### PAST MEDICAL HISTORY

◯Arthritis
◯A-Fib
◯Anemia
◯Angina
◯Arrhythmia
◯Asthma
◯Cancer _______________
◯Cardiomyopathy
◯COPD/Emphysema
◯Aneurysm
◯____________________
◯Carotid Disease
◯Heart Failure
◯Clotting Disorder
◯Coronary Artery Disease
◯Diabetes
◯Heart Murmur
◯High Cholesterol
◯High Blood Pressure
◯HIV/AIDS
◯Depression
◯_______________
◯Kidney disease
◯Heart Attack
◯Peripheral Arterial Disease (PAD)
◯Sleep Apnea
◯Stroke/TIA
◯Syncope (passing out)
◯Thyroid Disorder ◯Low ◯High
◯Blood Clots in Veins or Lungs
◯Liver Problems/Hepatitis **A B C**
◯Anxiety
◯______________________

### Past Surgical History

◯AAA Repair
◯Cardiac Ablation
◯ASD Repair
◯Coronary Bypass
◯Gall Bladder
◯Tonsils /Adenoids
◯Carpel Tunnel Release
◯Knee Replacement ◯Left ◯Right
◯Appendectomy
◯Carotid Stenting
◯Coronary Stenting
◯ICD
◯Pacemaker
◯Hysterectomy
◯Fracture_______________
◯Cataract ◯left ◯Right
◯_________________
◯Peripheral Stenting
◯Valve Repair/Replacement
◯VSD Repair
◯Cardioversion
◯C-Section
◯Vasectomy
◯Hip Replacement ◯left ◯Right
◯Knee Surgery_______________
◯______________________

**Family History**

| Relationship | Status | A-Fib | Coronary Artery Disease | Clotting Disorder | Diabetes | Heart Attack | Heart Disease | Heart Failure | High Cholesterol | High Blood Pressure | Stroke | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | |
| Father | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

◯ ADOPTED ◯FAMILY HISTORY UNKOWN