Faisal Bahadur, MD
Gautam Kedia, MD
Bashar Markabawi, MD, FACC

PATIENT MEDICAL HISTORY

Patient Name _____Date of Birth _____ Today's date_____

HEALTH HISTORY AND RISK FACTORS

Have you ever experienced or have been diagnosed with:

Congestive Heart Failure (CHF)	Yes	No	When? _____
Heart Attack (myocardial infarction, MI)	Yes	No	When? _____
High Blood Pressure (hypertension)	Yes	No	When? _____
Diabetes	Yes	No	When? _____
Stroke	Yes	No	When? _____
High Cholesterol	Yes	No	When? _____
Cancer	Yes	No	When? _____
Lung Disease	Yes	No	When? _____
Bleeding or Clotting Tendencies	Yes	No	When? _____
Thyroid Disorder	Yes	No	When? _____
Peripheral Vascular/Arterial Disease (PAD)	Yes	No	When? _____
Heart Valve Disease	Yes	No	When? _____
Other Major Illnesses: _____	Yes	No	When? _____

SURGERIES: What Procedure? _____ When? _____

What Procedure? _____ When? _____

What Procedure? _____ When? _____

HOSPITALIZATIONS:

Reason _____ When? _____

Reason _____ When? _____

WOMEN ONLY:

Hysterectomy? [ ] partial [ ] Full	Yes	No
Do you take Birth Control Pills?	Yes	No
Have you gone through Menopause?	Yes	No
Are you taking hormone replacements?	Yes	No

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CURRENT MEDICATION: *(if you have a list, just write "see list")*

Drug Name	Dosage (mg)	how many times a day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES:

Drug Name	Reaction
_____	_____
_____	_____
_____	_____

Other Allergies (food, adhesive tape, iodine, contrast dye, latex, etc)

_____ _____
_____ _____

Do you smoke? Yes No How Much? _____
Alcohol use? Yes No How Often? _____
Drug use? _____ Yes No How Often? _____
Caffeine use? _____ Yes No How Often? _____

FAMILY HISTORY: Please list major medical problems in immediately family members **(include age & indicate if alive or deceased)**:

Father: _____ Mother: _____

Brother or Sister: _____

PATIENT HEALTH CHECKLIST:

Constitutional
____ Significant weight change
____ Night sweats
____ Unexplained Fever

Eyes
____ Cataracts
____ Blurred or double vision
____ Glaucoma

ENMT
____ Difficulty swallowing
____ Dry, Hoarse throat
____ Dizziness

Cardiovascular
____ Chest discomfort
____ Shortness of breath
____Skipped beats/Palpitations
____ Fainting

Respiratory
____ Wheezing/Asthma
____ Chronic cough
____ Shortness of breath

Gastrointestinal
____ Indigestion/Reflux
____ Blood in stools
____ Constipation

Musculoskeletal
____ Joint pain
____ Back Pain
____ Muscle Weakness

Integumentary
____ Skin rash
____ Bruising
____ Bleeding

Neurological
____ Headache
____ Memory Loss
____ Speech problems

Psychological
____ Depression
____ Anxiety/Stress

Endocrine
____ Thyroid problems

Genitourinary
____Loss of bladder control
____ Blood in urine