



Review the list below and check “Y” for YES and “N” for NO in the appropriate box for any problems you are currently having:

Pt Name: \_\_\_\_\_

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

Chief Complaint: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Cardiologist: Dr. Samal / Vivek / Kuruvanka

**Social History**

Marital Status:

- Married  Single  Divorced  Separated  Widowed

Do you exercise each week?

- Never  Occasionally  Daily  2-3 times  4 or more times

Do you use alcohol?

- Never  Former  Daily  Frequently  Rarely  Socially

Do you use caffeine?  Yes  No

- Chocolate  Coffee  Soda  Tablets  Tea  Other

Residence:

- Assisted  Living  Live alone  Nursing Home

- With Family  With Spouse  Other

What is your occupation:

- Student  Retired  Currently Working

Are you currently under stress at work or home?

- Yes  No

**Past Medical History**

(Please list diagnosis date)

Y

N

Comment

Diabetes

Cancer

Stroke

Arthritis/Gout

Convulsions/Seizures

Bleeding Tendency

Hereditary defects

Rheumatic Fever

Abnormal Heart Rhythm

Asthma/emphysema/TB

Thyroid disease

Anemia

Migraines

Ulcers

Colitis

Hepatitis or HIV

Kidney disease

Psychiatric disorders

Other medical illnesses

**Past Surgical History**

Y

N

Date

CABG (heart bypass)

Valve Surgery

- If yes what type  Aortic  Mitral

Angioplasty

Cardiac Stent

Aortic Aneurysm Surgery

Peripheral Stent

Peripheral Bypass

Carotid Endarterectomy

- Location:  Left  Right  Bilaterally

Carotid Stent

- Location:  Left  Right  Bilaterally

Varicose Vein Procedures

**Other Surgeries**

Reason for today's visit and

Other information you feel we may need to know

Reviewing Cardiologist Signature / Date

Northwest Houston Cardiology PA

13325 Hargrave Road Suite #100

Houston, TX 77070

281-469-8007

Past Medical / Surgical History Pg 3

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