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**PATIENT HISTORY DATA SHEET**

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Sex: M / F  
 Age: \_\_\_\_\_ Height: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Bra Size (females): \_\_\_\_\_

**FAMILY DOCTOR**

Why are you seeing the doctor today?

\_\_\_\_\_

Have you ever had any of the following symptoms or conditions? Please check under Yes or No.

	Yes	No		Yes	No
1. Chest Pain	_____	_____	8. Rheumatic fever	_____	_____
2. High Blood pressure	_____	_____	9. Diabetes	_____	_____
3. High Cholesterol	_____	_____	10. Hepatitis	_____	_____
4. Shortness of breath	_____	_____	11. Asthma	_____	_____
5. Heart Palpitations	_____	_____	12. Emphysema	_____	_____
6. Heart Murmur	_____	_____	13. COPD	_____	_____
7. Congestive Heart Failure	_____	_____	14. Heart Attack	_____	_____
Any other chronic disease? _____					

Have you ever had any of the following procedures? Check yes or no. Give approximate date if known.

	Yes	No	Date		Yes	No	Date
1. EKG	_____	_____	_____	5. Angioplasty	_____	_____	_____
abnormal? (if yes)	_____	_____	_____	(balloon, PTCA, stent)	_____	_____	_____
2. Treadmill stress test	_____	_____	_____	6. Pacemaker	_____	_____	_____
abnormal? (if yes)	_____	_____	_____	7. Valve Surgery	_____	_____	_____
3. Nuclear stress test	_____	_____	_____	8. Heart bypass	_____	_____	_____
4. Cardiac Catheterization	_____	_____	_____	How many vessels?	_____		

Do you smoke? Y / N                      How many packs per day? \_\_\_\_\_  
 Have you ever smoked? Y / N                      When did you quit? \_\_\_\_\_

Is there a family history of heart disease? Y / N

Please list your current medications, including all over-the-counter meds.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_