Heart Center Medical History Questionnaire

The Heart Center, a division of Hudson Valley Cardiovascular Practice, P.C.

Name _____ Date _____ Age: _____

Primary Care Physician _____ Problem to be evaluated _____

Have you had any of the following:			Have you had any of these tests/procedures:		
Diabetes	Y	N	Stress Test/Nuclear Stress Test	Y	N
High Blood Pressure	Y	N	Echo/Heart Ultrasound	Y	N
High Cholesterol	Y	N	Cardiac Cath/Angioplasty	Y	N
Smoking History	Y	N	Bypass Surgery	Y	N
Heart Disease In Family	Y	N	Pacemaker	Y	N

Please list all hospitalizations and surgical procedures (use back of page if necessary):

Hospital	City	Reason	Year

Please list all current medications and *doses:*

Medication	Dose	Medication	

Do you have any drug allergies: No_____ Yes(list)_____ Dye Allergy: No_____ Yes_____

Family History (List any major Medical problems) If deceased, Age & Cause of Death:

Father _____ :

Mother: _____

Brother/Sister : _____

Occupation: _____ Retired: Y N Marital Status: M S D W

Amount Consumed per day: Alcohol: _____ Coffee/Tea: _____

Soft Drinks: _____ Illicit Drugs: _____

If you answer YES to any of the following, please explain on another sheet of paper:

	YES	NO
Recent Weight Gain		
Recent Weight Loss		
Loss Of Hearing		
Cough		
Abdominal Pain		
Vomiting		
Constipation		
Diarrhea		
Heartburn		
Blood In Stool		
Painful Urination		
Blood In Urine		

	YES	NO
Joint Pain		
Dizziness		
Seizure		
Double Vision		
Paralysis		
Hot Flashes		
Deepening Of The Voice		
Easy Bleeding		
Easy Bruising		
Anxiety		
Depression		

REVIEWED & SIGNED BY DOCTOR: _____ Date: _____