Health and Clinical History Form

Thank you for taking the time to fill out our health questionnaire. This information will assist the doctor and allow us to better serve your health needs. This is a confidential record of your medical history and will be kept in this office. If you are unsure about a question or answer, please insert a question mark (?) in the space.

Today's Date: _____ Patient Name: _____
Last, First

Sex: M☐ F☐ Date of Birth:_____ Age: _____

Occupation:_____ Ethnicity: _____

Reason for visit today: _____

Referring Doctor: _____

Past Medical History

Please ✔ all that apply:	***Date(s):***	***Where? Location?***
☐ Heart Attack		
☐ Heart Catheterization		
☐ Angioplasty/Stent		
☐ Heart Murmur / Valve Prolapse		
☐ Bypass Surgery (CABG)		
☐ Congestive Heart Failure		
☐ CT Angiogram		
☐ Echocardiogram / Heart Ultrasound		
☐ Holter Monitor		
☐ Implanted Pacemaker or Defibrillator		
☐ Stress Test (Treadmill test)		
☐ Congenital Heart Disease: *What type?*		
☐ Angina/Chest Pain: *How frequent?*		
☐ Congenital Heart Disease: *What type?*		
☐ Light-headedness / Dizziness / Fainting		
☐ Palpitations		
☐ Rheumatic Fever: *At what age?*		
☐ Rheumatic Heart Disease: *What type?*		
☐ Shortness of Breath on exertion		
☐ Shortness of Breath – *requiring (2) or more pillows for comfortable sleep*		
☐ Swelling in the ankles		
☐ Unusual Fatigue		

Cardiovascular Risk Factors

Please ✓ all that apply:

☐	Current Smoker:	*How Long?*	_____	*How many packs/day?*	_____
☐	Previous Smoker:	*How Long?*	_____	*When did you quit?*	_____
☐	High Blood Pressure:	*How Long?*	_____	*Under Current treatment?*	_____
☐	High Cholesterol:	*How Long?*	_____	*Under Current treatment?*	_____
☐	Stroke or TIA (ministroke):	*When?*	_____		
☐	Number of alcoholic drinks per week		_____		
☐	Diabetes				
☐	Venous (leg) clots				
☐	Exercise 3 times a week or more			*What type?*	_____
☐	On a special diet plan:			*What type?*	_____
☐	Leg Cramps w/walking: *How long can you walk before pain?*				_____
☐	Immediate family history of heart disease				

Rate your level of stress over the last 12 months *(circle the appropriate rating):*

Low				***Moderate***				***High***	
1	2	3	4	5	6	7	8	9	10

Rate your level of stress over the last 30 days *(circle the appropriate rating):*

Low				***Moderate***				***High***	
1	2	3	4	5	6	7	8	9	10

How do you relieve tension and stress? _____

Current Medications

Please list all current medications INCLUDING vitamins and/or supplements that you are taking:

Medicine	***Dose/Strength***	***Frequency/Day***

If more space is needed, please write on back of this form. Thank you.

Allergies *(Drug, Food, Environmental):* *Please list any allergies and reaction:*

_____

_____

_____

Past Surgical History and Hospitalizations *(In chronological order)*:

	Reason / Approximate Date		Reason / Approximate Date
1.	_____	5.	_____
2.	_____	6.	_____
3.	_____	7.	_____
4.	_____	8.	_____

Family Medical History *(Please indicate the current health status of each of your family members):*

(If deceased, please indicate cause and approximate age at time of death)

Father: _____

Mother: _____

Siblings: _____

Social and Personal History (*Please ✓ appropriate box)*

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Where were you born? _____ Highest level of education? _____

Children: *How Many?* *What ages?*

How long have you lived in San Diego or wherever you currently reside?

_____

Notes: *(Office Use Only)*