

CASCADE HEART PATIENT HISTORY



Name: _____ Birth date: _____ Do you have Living Will: Yes / No

Place of birth: _____ Spouse's health: _____ Number of children: _____ Ages: _____

DO YOU SMOKE: Yes / No If yes, how many packs per day: _____ If you are an ex-smoker, when did you quit? _____
How many years did you smoke? _____

COFFEE INTAKE cups per day: _____ TEA INTAKE cups per day: _____ SOFT DRINKS oz. per day: _____

ALCOHOL INTAKE oz. per day: _____

DIABETES: Yes / No How long? Years _____ Months _____ Insulin? Yes / No HIGH BLOOD PRESSURE: Yes / No

HIGH CHOLESTEROL: Yes / No

CIRCLE ILLNESSES OR CONDITIONS YOU HAVE HAD:

Heart Attack	Heart Murmur	Congestive Heart Failure	Asthma	Jaundice
Bleeding Tendencies	Blood clots/Phlebitis	Pneumonia	Kidney Disease	Rheumatic Fever
Tuberculosis	Psychiatric Disorder	Cancer	Thyroid	

OTHER: _____

IMMUNIZATIONS: Influenza: Yes / No Year: _____ Pneumonia: Yes / No Year: _____

CIRCLE TESTS YOU HAVE HAD: Treadmill Test Coronary Angiogram Coronary Angioplasty

HAVE YOU EVER HAD A BLOOD TRANSFUSION: Yes / No If yes, when _____

LIST HOSPITALIZATIONS, SURGERIES AND ANY OTHER MEDICAL PROBLEMS:

MEDICATIONS: Bring all medications with you to your appointment, including vitamins and herbal supplements.

ALLERGY TO MEDICATIONS? Yes / No If yes, please list: _____

ALLERGY TO IODINE OR SHELLFISH? Yes / No

FAMILY HISTORY

FATHER Alive? Yes / No Age: _____ Present Health: _____

Deceased Age: _____ Cause of death: _____

MOTHER Alive? Yes / No Age: _____ Present Health: _____

Deceased Age: _____ Cause of death: _____

BROTHERS How many: _____ Ages: _____ Health: _____

SISTERS How many: _____ Ages: _____ Health: _____

Additional information may be added on back

Revised 4/19/03