WESTSIDE | CARDIOLOGY

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# MEDICAL/SURGICAL PATIENT HISTORY

Name:_____ Date:_____

Medical / Psychiatric problems **and** year diagnosed:

_____ _____
_____ _____
_____ _____
_____ _____

Surgeries **and** year performed:

_____ _____
_____ _____
_____ _____

All current medications: (prescription, over-the-counter, herbal/vitamins and doses)

_____ _____
_____ _____
_____ _____
_____ _____

Other physicians caring for you (please include phone #)

_____ _____
_____ _____
_____ _____

Allergies (medicine and/or food):

_____ _____
_____ _____
_____ _____

Smoke: **Y/N** Packs/day: Year quit:
Alcohol: **Y/N** Drinks/day: Year quit:
Substance abuse: **Y/N** What substance(s): Year quit:
Caffeine intake/day:
Are you experiencing any physical or emotional abuse? **Y/N**

List family members who have had: Heart attack, chest pain, stroke, congestive heart failure, arrhythmia, fainting, unexplained death (please include their age when diagnosed):

_____
_____
_____
_____