

Health History Continued

WHAT MEDICATIONS DO YOU HAVE AN ALLERGIC REACTION TO?

MEDICATIONS:	REACTION:	MEDICATIONS:	REACTION:

HEALTH HISTORY

Check the box if you have a **FAMILY HISTORY** of the following: () Father () Mother () Brother () Sister

- Heart Attack Stroke Diabetes High Blood Pressure High Cholesterol
 PVD, Abdominal Aortic Aneurysm Sudden Cardiac Death

Check the box if you have a **PERSONAL HISTORY** of any of the following:

- Heart Surgery/Procedures**
 Aneurysm Surgery
 Carotid Surgery If yes, how is it treated? _____
 Vascular Surgery/Procedures If yes, how is it treated? _____
 Diabetes If yes, when? _____
 High Blood Pressure If yes, when? _____
 High Cholesterol If yes, when? _____
 Stroke If yes, when? _____
 Palpitations If yes, when? _____
 Chest Pain If yes, when? _____
 COPD If yes, how is it treated? _____
 Congestive Heart Failure If yes, when? _____
 Asthma If yes, when? _____

- How many alcoholic beverages do you consume each day? _____
 How many caffeinated beverages do you consume each day? _____
 Do you smoke? If so, how much each day? If you quit smoking, how long ago? _____
 Do you exercise? If so, how often and what type? _____
 Do you have a history of or currently use recreational drugs? If so, what type? _____
 Do you have advanced directives? If so, please provide us with a copy for your chart.

Please check any major hospitalization

- | | | |
|-----------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cardiac Complaint | <input type="checkbox"/> Fainting | <input type="checkbox"/> Peripheral Vascular Complaint |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Congestive Heart Failure | Name of Hospital: _____ |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Arrhythmia | Date: _____ |

Are there any other problems we should be aware of? _____
