THE CARDIOVASCULAR CARE GROUP
MEDICAL INFORMATION

NAME: _____ DATE: _____

1. REGARDING YOUR PAST MEDICAL HISTORY:

	YES	NO
Do you have *high blood pressure*?		
Do you have *Diabetes*?		
If so, do you take *insulin*?		
Do you have *heart problems*?		
Have you had a prior *heart attack*? What year? _____		
Do you have *angina*?		
Do you have *high cholesterol*?		
Do you have *lung disease*? If yes, please list_____		
Do you have *kidney disease*?		
If so, are you on dialysis? When did you begin? _____		
Do you have problems with your *liver*?		
Have you ever had a *stroke or TIA*?		
Do you have *Rheumatoid Arthritis*?		
Have you ever had *Cancer*?		

2. PLEASE LIST ALL OF YOUR MEDICATIONS – include supplements and herbals:

MEDICATION NAME	DOSAGE	FREQUENCY

3. PLEASE LIST ANY ALERGIES YOU HAVE:

4. HAVE YOU HAD ANY PRIOR SURGERIES? If so, please list:

OPERATION PERFORMED	YEAR

(Over)

5. REGARDING YOUR SOCIAL HISTORY:

	YES	NO
Are you currently employed?		
In not, are you retired? If so, from what? _____		
Have you been exposed to any known toxins? If so, list _____		
Do you presently smoke? If yes, how much? _____		
If no, have you ever smoked regularly? When _____		
Do you drink alcohol? If yes, how much? _____		
Do you live alone? If not, with whom do you live? _____		

6. REGARDING YOUR FAMILY HISTORY?

	MOTHER		FATHER		SIBLINGS	
ALIVE	YES	NO	YES	NO	YES	NO
Age at Passing or present						
Cause of Death						
Diabetes						
Heart Disease						
High Blood Pressure						
Cancer (specify)						

7. GENERAL OVERALL CONDITION (PLEASE EXPLAIN ALL "YES" RESPONSES):

	YES	NO	
Have you had a persistent *fever*?			
Have you *lost/gained weight* in the last six months?			
Have you been excessively *fatigued or irritable*?			
Have you had problems with your *eyes*?			
Have you had partial *loss of vision* in either eye?			
Have you had problems with your *ears*?			
Have you had *swallowing problems*?			
Have you had *dental problems*?			
Have you had *chest pains or palpitations*?			
Have you had *shoulder or neck pain*?			
Do you have *pain in your leg(s)* when you walk?			Which leg? Right Left
How far can you walk (in blocks)?			
Do your *ankles* swell?			
Have you ever had *phlebitis or DVT*?			
Do you get *short of breath*? If so, explain _____			
Do you have a *cough* and/or produce *sputum*?			
Do you have *nausea, vomiting or diarrhea*?			
Have you had *blood* in your *urine or stools*?			
Do you have problems *urinating*?			
Do you have *joint pains* (knee, elbow, shoulders)?			
Do you *bruise* easily?			
Do you have *discoloration* of your skin?			
Do you have *dizziness or numbness*?			
Do you have difficulty *speaking*?			