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)