LIVE OAK
CARDIOLOGY

PATIENT NAME: _____ DATE: _____

DOB: _____

PAST MEDICAL AND SOCIAL HISTORY FORM

Have you ever had any of these cardiovascular diseases? Circle yes (Y) or no (N).

Known Heart Disease	Y/N	High Blood Pressure	Y/N
Heart Attack	Y/N	Abnormal EKG	Y/N
Enlarged Heart	Y/N	Blood Clots in the Veins of Legs	Y/N
Heart Valve Problems	Y/N	Blockage in the Neck Arteries	Y/N
Atrial Fibrillation	Y/N	Aneurysm of the Aorta	Y/N
Other Abnormal Heart Rhythm	Y/N	Heart Murmur	Y/N

Have you ever had any of these procedures done? Circle yes (Y) or no (N).

Coronary Bypass Surgery	Y/N	Heart Artery Balloon or Stent	Y/N
Pacemaker Implantation	Y/N	Leg Artery Balloon or Stent	Y/N
Defibrillator Implantation	Y/N	Leg Arterial Surgery or Bypass	Y/N
Neck Artery Surgery or Stent	Y/N	ABI (ankle-brachial indices) Exam	Y/N
Heart Catheterization	Y/N	Holter Monitor or Event Monitor	Y/N
Electrophysiology Study	Y/N	Cardiac Echocardiogram	Y/N
Aortic Aneurysm	Y/N	Stress Test	Y/N
Heart Valve Surgery	Y/N	Cardiac Stress Nuclear Scan	Y/N

Please circle any of the medical problems below that you have or had in the past.

Allergies	COPD	Headaches	Sleep Apnea	Tuberculosis
Angina	Depression	High Cholesterol	Sleep Disorder	
Anxiety Disorder	Diabetes	Hyperlipidemia	Strokes	
Asthma	Gall Stones	Kidney Disease/Stones	Thyroid trouble	
Atrial Fibrillation	GERD (Reflux)	Pacemaker	TIA	
Cancer	Gout	Seizure	Tumor	

Please answer these questions to the best of your knowledge:

Occupation _____ Marital Status: **Single/Married/Divorced/Widowed**

Live alone or with others? _____ Number of children: _____

General Stress Level: **Low/Medium/High** Are you on a specific diet:_____

Do you exercise? **Y/N** If so, what type of exercise? _____

Do you consume Alcohol? **Y/N** If so, how many glasses per week? _____
Alcohol – yrs of use? _____

Do you smoke? **Y/N** Have you ever smoked? **Y/N** Tobacco – yrs of use? _____
How many packs do you (or did) smoke per day on average?_____

How many caffeinated beverages do you drink a day? _____

Have you ever used illicit drugs**? (Cocaine, marijuana, heroin, etc.) Y/N**
Please explain here: _____ Years of use? _____

Advance directive: **Y/N**

Surgical history: