# Memorial Hermann Medical Group
# New Patient Medical History - Cardiology

Today's Date: ____________________

Patient Name: ____________________________________________ Date of Birth: ____________________

Primary Care Physician: ____________________________________________

Referring Physician (if different): ____________________________________________

Reason for your visit: ____________________________________________

How did you hear about us? ____________________________________________

Do you take Aspirin daily? ☐ Yes ☐ No ☐ Sometimes

**FAMILY MEDICAL HISTORY: PLEASE MARK (X) ANY CONDITIONS THAT APPLY TO YOUR FAMILY MEMBERS**

| DISEASE | FATHER | MOTHER | BROTHER | SISTER | CHILD | OTHER |
|---|---|---|---|---|---|---|
| Aneurysm | | | | | | |
| Abnormal heart rhythm | | | | | | |
| Bleeding/clotting disorder | | | | | | |
| Cancer (body part) | | | | | | |
| Diabetes | | | | | | |
| Heart attack (male, <55) | | | | | | |
| Heart attack (female, <65) | | | | | | |
| Heart disease | | | | | | |
| High blood pressure | | | | | | |
| High cholesterol | | | | | | |
| Stroke | | | | | | |
| Sudden death (cardiac) | | | | | | |
| Thyroid disease | | | | | | |

**PERSONAL MEDICAL HISTORY: PLEASE MARK ANY CONDITIONS THAT APPLY TO YOU**

**Please mark any conditions that apply to you.**

☐ Aneurysm
☐ Abnormal heart rhythm
☐ Bleeding/clotting disorder
☐ Cancer: ____________________
☐ Diabetes
☐ Emphysema
☐ Heart attack (cardiac arrest)
☐ Heart disease
☐ Heart failure
☐ High blood pressure
☐ High cholesterol
☐ Kidney disease
☐ Stroke
☐ Thyroid disease
☐ Valve disease (description):
____________________________
☐ Vein disease
☐ Other: ____________________

MEMORIAL HERMANN

MHMG New Patient Medical History - Cardiology

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## PROCEDURE HISTORY: PLEASE LIST THE DATES OF ANY PROCEDURE YOU HAVE HAD

Aneurysm repair ______________________________

Bypass (CABG)(# of grafts) ____________________

Carotid artery surgery ________________________

Defibrillator __________________________________

ECHO ________________________________________

Heart catheterization __________________________

Pacemaker ____________________________________

Stents placed (how many):______________________

Stress test ____________________________________

Valve surgery (which valve): ___________________

Vein surgery ___________________________________

Other _________________________________________

## SOCIAL HISTORY

**Tobacco Use:** ☐ Current every day ☐ Current some days ☐ Former ☐ Never

Type (if applicable): ____________________________________________

Tobacco Exposure: ☐ None ☐ At Work ☐ At Home

If you're a current or past smoker, have you smoked in the last year? ☐ Yes ☐ No

**Alcohol Use:** ☐ Current ☐ Past ☐ Never

Type (if applicable): ☐ Beer ☐ Wine ☐ Liquor

How often: ☐ 1-2x/year ☐ 1-2x/month ☐ 1-2x/week ☐ 3-5x/week ☐ daily ☐ 2x/day

**Substance Use:** ☐ Current ☐ Past ☐ Never

Type (if applicable): ____________________________________________

**Exercise:** ☐ Light Exercise ☐ Moderate Exercise ☐ Vigorous/High Intensity Exercise

If yes, how many days per week? __________________________________

If yes, how many minutes per session? ______________________________

**Occupation:** ____________________________________________ ☐ Student ☐ Retired

Have you ever been pregnant? ☐ N/A ☐ No ☐ Yes

Did you have any complications during your pregnancies? ☐ N/A ☐ No ☐ Yes

If yes, list complications here:_____________________________________

______________________________________________________________

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## MEDICATIONS

☐ **I am not taking any medications.**

☐ **I brought a list of my medications from home. [You do not need to write down your medications if you brought a complete list].**

**List all medications prior to assessment. Include over-the-counter, alternative medications, herbals and prescriptions.**

| MEDICATION NAME | STRENGTH | NUMBER OF PILLS AT ONE TIME? | HOW MANY TIMES A DAY? | PRESCRIBER | TAKING AS PRESCRIBED? |
|---|---|---|---|---|---|
| Example: *Tylenol* | *100mg* | *1* | *2* | *Dr. Smith* | ☒ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

Local Pharmacy: ______________________ Phone Number: ______________________

Mail Order Pharmacy: ______________________ Phone Number: ______________________

## ALLERGIES

☐ **No Known Allergies**

| MEDICATION / FOOD / ENVIRONMENTAL | REACTION | SEVERITY |
|---|---|---|
| | | ☐ Mild ☐ Moderate ☐ Severe |
| | | ☐ Mild ☐ Moderate ☐ Severe |
| | | ☐ Mild ☐ Moderate ☐ Severe |
| | | ☐ Mild ☐ Moderate ☐ Severe |
| | | ☐ Mild ☐ Moderate ☐ Severe |
| | | ☐ Mild ☐ Moderate ☐ Severe |
| | | ☐ Mild ☐ Moderate ☐ Severe |

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## REVIEW OF SYSTEMS

Cardiovascular:

- ☐ Chest pain, pressure, heaviness
- ☐ Dizziness/fainting
- ☐ Leg pain with walking
- ☐ Palpitations/irregular heart beat
- ☐ Shortness of breath
- ☐ Swollen legs/ankles

General:

- ☐ Fever
- ☐ Loss of appetite
- ☐ Weight gain/loss

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Bloody cough

Musculoskeletal:

- ☐ Joint pain
- ☐ Joint swelling

Neurologic:

- ☐ Numbness
- ☐ Loss of balance
- ☐ Weakness
- ☐ Paralysis

Vision:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Vision problems

Digestive:

- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Heartburn/ulcers/pain

Dermatologic:

- ☐ Skin rashes/sores
- ☐ Itching

Psychiatric:

- ☐ Anxiety
- ☐ Depression

I have completed the above to the best of my knowledge.

| **Patient / Guardian Signature** | **Print Name** | **Relationship to patient** | **Date** |
|---|---|---|---|