



CARDIOTHORACIC PRE-VISIT
MEDICAL HISTORY AND MEDICATION FORM

PATIENT INFORMATION

Patient Name _____
Today's Date _____
Referring Physician _____
Family Physician _____
Date of Birth _____ Age _____
Height _____ feet _____ in Weight _____
Gender _____ Marital Status _____
Number of Children _____

PERSONAL HEALTH HISTORY

What is the reason for this visit? _____

Have you ever had a heart problem?
If yes, please explain: _____

Do you have or have you ever had any of the following?
Please check all that apply and provide the date.

	Name	Date
<input type="checkbox"/>	Rheumatic fever	
<input type="checkbox"/>	Heart murmur	
<input type="checkbox"/>	Heart attack	
<input type="checkbox"/>	Chest pain/pressure	
<input type="checkbox"/>	Heart failure	
<input type="checkbox"/>	Rapid heart beat or irregular pulse	
<input type="checkbox"/>	Light-headedness	
<input type="checkbox"/>	Dizziness	

FAMILY HISTORY

Do you have a history of heart disease in your family?

If yes, indicate relation and age problems started _____

Family member(s):

Please complete the following table.

Relative	Status	Current Age or Age at Death	Cause of Death
Mother			
Father			
Sister(s)			
Brother(s)			