



**GOWANI MEDICAL ASSOCIATES, MD. PA**

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**Patient History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Ref: Physician: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ DOB: \_\_\_\_\_

<p><b><u>CARDIAC SYMPTOMS</u></b></p> <p style="text-align: right; margin-right: 20px;"><b><u>How long</u></b></p> <p>Chest Pain /Chest pressure/discomfort .... Y / N _____</p> <p>Left arm pain/numbness..... Y / N _____</p> <p>Palpitations (feel heart beating fast)..... Y / N _____</p> <p>Short of breath (walking / lying flat)..... Y / N _____</p> <p>Swelling of feet, ankles or hands..... Y / N _____</p> <p>Lightheadedness, dizziness, or fainting..... Y / N _____</p> <p>Pain in legs when walking..... Y / N _____</p> <p>Weight Gain/ Loss..... Y / N _____</p> <p><b><u>PAST MEDICAL HISTORY</u></b></p> <p>Heart Attack /MI ..... Y / N _____</p> <p>Coronary artery Bypass surgery ..... Y / N _____</p> <p>Heart Valve Surgery..... Y / N _____</p> <p>Coronary artery disease ..... Y / N _____</p> <p>Angioplasty/Stent..... Y / N _____</p> <p>Pacemaker Or ICD..... Y / N _____</p> <p>Congestive Heart Failure/ CHF..... Y / N _____</p> <p>Irregular Heart Beat/ Arrhythmias..... Y / N _____</p> <p>Atrial Fibrillation/A-FIB ..... Y / N _____</p> <p>Heart Murmur / Valve Disease..... Y / N _____</p> <p>Congenital Heart Disease ..... Y / N _____</p> <p>High Blood Pressure..... Y / N _____</p> <p>High Cholesterol..... Y / N _____</p> <p>Blockage in leg (PVD) Or Blood Clot..... Y / N _____</p> <p>Diabetes Type I or II..... Y / N _____</p> <p>Stroke / Mini-Stroke / TIA..... Y / N _____</p> <p>Bleeding Tendencies..... Y / N _____</p> <p>Kidney Trouble..... Y / N _____</p> <p>Backache/Arthritis / Gout..... Y / N _____</p> <p>Lung Diseases / Asthma / COPD..... Y / N _____</p> <p>Sleep Apnea..... Y / N _____</p> <p>Are you taking any blood thinner..... Y / N _____</p> <p>Other Disease: ..... Y / N _____</p>	<p><b><u>Previous Hospitalizations:</u></b></p> <p>Recent Cardiac Hosp..... Y / N Date: _____</p> <p>Open Heart Surgery..... Y / N Date: _____</p> <p>Any other surgeries:..... Y / N Date: _____</p> <hr/> <p><b><u>Previous Diagnostic test:</u></b></p> <p>Echocardiogram..... Y / N Date: _____</p> <p>EKG..... Y / N Date: _____</p> <p>Nuclear Stress Test..... Y / N Date: _____</p> <p>Stress or Treadmill Test..... Y / N Date: _____</p> <p>Carotid U/S:..... Y / N Date: _____</p> <p>Holter Monitor..... Y / N Date: _____</p> <p>MRI /CT /Chest-X-ray..... Y / N Date: _____</p> <p>Other test..... Y / N Date: _____</p> <p><b><u>ALLERGIES</u></b> <span style="float: right;"><b><u>Reactions:</u></b></span></p> <p>Contrast Dye..... Y / N _____</p> <p>Penicillin..... Y / N _____</p> <p>Morphine, Demerol,..... Y / N _____</p> <p>Aspirin..... Y / N _____</p> <p>Iodine, or shell fish..... Y / N _____</p> <p>Drugs / Medications _____</p> <hr/> <p><b><u>SOCIAL HISTORY:</u></b></p> <p><b>What is your Occupation :</b> _____</p> <p><b><u>Marital Status:</u></b> Single / Married / Divorced / Widowed</p> <p><b><u>Use of Tobacco:</u></b> Never / Prev. Quit in _____ Amount: _____</p> <p><b><u>Smoker...</u></b> Y / N: Per day _____ How long _____ Quit: _____</p> <p><b><u>Use of Alcohol:</u></b> Never / Moderate / Daily _____</p> <p><b><u>Use of Drugs:</u></b> Never / Type of drug / How often _____</p> <p><b><u>Use of Caffeine:</u></b> Never / Moderate / Daily Amount: _____</p> <p><b><u>Exercise:</u></b> Never / Moderate / Daily Type: _____</p>
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**MEDICATIONS:**

Name of Medicine (currently taking)	Dosage	How often do you take?	Prescribing Doctor?
1.			
2.			
3.			
4.			
5.			

## FAMILY HISTORY:

Heart attack, Open-Heart Surgery, Angina, Angioplasty/Stent, Congestive heart failure, Cardiac arrhythmia, Peripheral vascular disease, abdominal aortic aneurysm, cardiac tumor, congenital heart disease, high cholesterol, high blood pressure, diabetes, stroke, pacemaker.

Family Member	Alive or Deceased	Age or Age at Death	Medical Problems or Cause of Death	Coronary Artery Disease (Yes/No) If yes, age first noted
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Brother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Brother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Children	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Grandparents	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Other	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Other	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes <input type="checkbox"/> No Age:

## LIST ALL THE DOCTOR WHOM YOU SEE:

Doctor's name	Type of Doctor/ Specialty	Telephone #	Date:
1.			
2.			
3.			
4.			
5.			

Please let us know your pharmacy name and phone# \_\_\_\_\_

## Additional Information

Please write below any other information not covered in the questionnaire that you think is important to your cardiac care or that you would like to discuss with your doctor or bring to your doctor's attention.

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I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

*Please fill out this questionnaire and either fax to (407) 352-6450 or deliver to Gowani Medical Associates on your next appointment.*