GOWANI MEDICAL ASSOCIATES, MD. PA
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Interventional Cardiology and Peripheral Vascular Disease
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Patient History

Name: _____ **Date:** _____ **Ref: Physician**: _____

Reason for Visit: _____ _____ **DOB:** _____

CARDIAC SYMPTOMS

	How long
Chest Pain /Chest pressure/discomfort ….Y / N	_____
Left arm pain/numbness.....Y / N	_____
Palpitations (feel heart beating fast).....Y / N	_____
Short of breath (walking / lying flat).....Y / N	_____
Swelling of feet, ankles or hands.....Y / N	_____
Lightheadedness, dizziness, or fainting.....Y / N	_____
Pain in legs when walking.....Y / N	_____
Weight Gain/ Loss……Y /N	_____

PAST MEDICAL HISTORY

Heart Attack /MI ……..... Y / N _____
Coronary artery Bypass surgery ……...….Y / N _____
Heart Valve Surgery……...Y / N_____
Coronary artery disease ……Y / N_____
Angioplasty/Stent…….. Y /N_____
Pacemaker Or ICD..... Y / N _____
Congestive Heart Failure/ CHF.....Y / N _____
Irregular Heart Beat/ Arrhythmias……..….Y / N _____
Atrial Fibrillation/A-FIB ……..Y / N_____
Heart Murmur / Valve Disease.....Y / N_____
Congenital Heart Disease .....Y / N _____
High Blood Pressure.....Y / N _____
High Cholesterol..... Y / N _____
Blockage in leg (PVD) Or Blood Clot..... Y / N _____
Diabetes Type I or ÌI..... Y / N _____
Stroke / Mini-Stroke / TIA..... Y / N _____
Bleeding Tendencies.....Y / N _____
Kidney Trouble.....Y / N _____
Backache/Arthritis / Gout..... Y / N _____
Lung Diseases / Asthma / COPD….....Y / N _____
Sleep Apnea.....Y / N _____
Are you taking any blood thinner……...Y / N_____
Other Disease: ……..Y / N_____

Previous Hospitalizations:

Recent Cardiac Hosp...:……Y / N Date: _____
Open Heart Surgery.....Y / N Date: _____
Any other surgeries:…… Y/ N Date: _____
_____

Previous Diagnostic test:

Echocardiogram….....Y / N Date: _____
EKG……Y/ N Date: _____
Nuclear Stress Test…….....Y / N Date: _____
Stress or Treadmill Test……..Y / N Date: _____
Carotid U/S:.....Y / N Date: _____
Holter Monitor……Y/ N Date: _____
MRI /CT /Chest-X-ray…….Y/ N Date: _____
Other test..... Y / N Date: _____

ALLERGIES Reactions:

Contrast Dye……Y / N _____
Penicillin.....Y / N _____
Morphine, Demerol,.....Y / N _____
Aspirin…….....Y / N _____
Iodine, or shell fish.....Y / N _____
Drugs / Medications _____
_____

SOCIAL HISTORY:

What is your Occupation :_____

Marital Status: Single / Married / Divorced / Widowed
Use of Tobacco: Never / Prev. Quit in _____Amount:___
Smoker…Y / N: Per day_____How long ____Quit:_____
Use of Alcohol: Never / Moderate / Daily _____
Use of Drugs: Never / Type of drug / How often _____
Use of Caffeine: Never / Moderate / Daily Amount:_____
Exercise: Never / Moderate / Daily Type:_____

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	**□□Alive □□Deceased**			**□Yes □ No Age:**
Mother	**□□Alive □□Deceased**			**□Yes □ No Age:**
Brother	**□□Alive □□Deceased**			**□Yes □ No Age:**
Brother	**□□Alive □□Deceased**			**□Yes □ No Age:**
Sister	**□□Alive □□Deceased**			**□Yes □ No Age:**
Sister	**□□Alive □□Deceased**			**□Yes □ No Age:**
Children	**□□Alive □□Deceased**			**□Yes □ No Age:**
Grandparents	**□□Alive □□Deceased**			**□Yes □ No Age:**
Other	**□□Alive □□Deceased**			**□Yes □ No Age:**
Other	**□□Alive □□Deceased**			**□Yes □ 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.

_____
_____
_____
_____
_____

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.