Cardiology Consultants of Houston, L.L.P.
Confidential Health History

Name:		Date of Birth:	Age:	Date:
Sex: Male Female	Marital Status:	Occupation:		
Height:	Weight:			

Reason/Concern for Visit

Review of Symptoms – Do you currently, or in the past year, have you had any of the following conditions?

Fever/Chills	Y NO		Chest Pain	Y NO	Unexplained Cough	Y NO
Weight Gain/Loss	Y NO		Palpitations	Y NO	# of Pillows to Sleep	1 2 3
Fatigue	Y NO		High Blood Pressure	Y NO		
Frequent Headaches	Y NO		Swollen feet/ankles	Y NO	Reflux	Y NO
Depression/Anxiety	Y NO		Leg Pain while walking	Y NO	Nausea/Vomiting	Y NO
			Dizziness/Fainting	Y NO	Frequent Urination	Y NO
Hearing Loss	Y NO				Loss of Bladder Control	Y NO
Visual Changes	Y NO		Blood in Stool	Y NO	Erectile Dysfunction	Y NO
Bleeding Gums	Y NO		Constipation	Y NO	**Muscle/Joint/Bone (note location)**	
Sinus Problems	Y NO		Ulcers	Y NO	Pain	
Bruising	Y NO		Heartburn/Indigestion	Y NO	Swelling	
Hives/Rashes	Y NO		Shortness of Breath	Y NO	Tenderness	
					Bone Density	

Medical History – Check (✓) the medical conditions you currently have or have had in the past.

☐ HIV/AIDS	☐ Epilepsy	☐ Phlebitis/Blood Clots
☐ Alcoholism	☐ Gall Bladder Disease	☐ Prostate Problem
☐ Anemia	☐ Glaucoma	☐ Sleep Apnea
☐ Appendicitis	☐ Gout	☐ Stroke/TIA
☐ Arthritis	☐ Heart Disease/Heart Attack	☐ Thyroid Problems
☐ Asthma	☐ Hepatitis	☐ Tuberculosis
☐ Bleeding Disorders	☐ Herpes	☐ Ulcers
☐ Bronchitis	☐ High Cholesterol	☐ Venereal Disease
☐ Bulimia	☐ Kidney Disease	Other Conditions:
☐ Cancer	☐ Liver Disease	
☐ Cataracts	☐ Migraine Headaches	
☐ Chemical Dependency	☐ Miscarriage	
☐ Diabetes	☐ Multiple Sclerosis	
☐ Emphysema/COPD	☐ Pacemaker	

Date of Birth:	Date:	Name:

Medication Allergies	**Type of Reaction**
Do you have an allergy to Iodine? Yes No	Do you have an allergy to shrimp or shellfish? Yes No
Do you have an allergy to Dye or Contrast Yes No	

Past Surgical History – Please list previous surgical procedures.	**Date/Year**

Family History	**Current Age(s) or Age at Death**	**Health Problems such as heart problems, hypertension, diabetes, high cholesterol, stroke.**	**Physician Comments**
Father Age:_______	Alive or Deceased		
Mother Age:_______	Alive or Deceased		
Brother(s) - #			
Age:_______	Alive or Deceased		
Age:_______	Alive or Deceased		
Age:_______	Alive or Deceased		
Sister(s) - #			
Age:_______	Alive or Deceased		
Age:_______	Alive or Deceased		
Age:_______	Alive or Deceased		
Children - #			
M F Age:_______	Alive or Deceased		
M F Age:_______	Alive or Deceased		
M F Age:_______	Alive or Deceased		
M F Age:_______	Alive or Deceased		

Personal Habits

Cigarettes/ Tobacco	**Alcohol**	**Substance Abuse**
Have you ever smoked? ❒ Yes ❒ No	Do you drink now? ❒ Yes ❒ No	Have you ever had or do you currently have a substance abuse (drug) problem? ❒ Yes ❒ No
If yes, how long ago did you quit? __________	If yes, how many drinks per day? __________	If yes, what type of drug and frequency of use.
How many packs per day did you smoke? _________	How many days per week? ___________	
How many years did you smoke? ___________	If no, how long ago did you quit? __________	

Caffeine Intake

Coffee _________ cups per day	Tea ___________ cups per day	Canned Sodas _________ per day

Person Completing This Form/Relationship to Patient **Reviewed by Physician** **Date**