

Cardiology Services of East Texas

History and Physical

Name: _____ DOB: ____/____/____ Date: _____

Height _____ Ft' _____ In" Reason For Visit: _____

Medical History

Atrial Fibrillation(afib):	Y	N	Diabetes:	Y	N
Arrhythmia:	Y	N	Heart Murmur:	Y	N
Cancer:	Y	N	Hypertension(HTN):	Y	N
Congestive Heart Failure(CHF):	Y	N	High Cholesterol:	Y	N
Coronary artery Disease(CAD):	Y	N	Kidney Disease:	Y	N
Stroke:	Y	N	Other:_____		

Do you currently use tobacco? Y N :Type_____ How much? _____/Day
 Have you ever used tobacco? Y N :Type_____ How much? _____/Day
 Do you consume alcohol? Y N :Frequency _____

Surgical History

Coronary artery bypass graft:	Y	N
Catheterization:	Y	N
Stent Placement:	Y	N
ICD/Pacemaker:	Y	N
Other:_____		

Family History *(Check all that apply)*

Relation	Hypertension	Diabetes	Coronary Artery Disease	Stroke	Myocardial Infarction	Congestive Heart Failure	Atrial Fibrillation	Cancer & Type	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____

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