Southwest CVA
Cardiovascular Associates

03 - PATIENT MEDICAL HISTORY

Please check all medical issues you have now or have had in the past:

Heart Disease	☐ Yes	☐ No	**Heart Murmur**	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No
Renal *(Kidney)* **Failure**	☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	**Anesthesia Problems**	☐ Yes	☐ No
Intestinal Disease	☐ Yes	☐ No	**Valley Fever/TB**	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	**Drug Abuse**	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	*If Yes, Type of Cancer:* _____		

SURGICAL PROCEDURES & OPERATIONS

Please list all previous surgical procedures and operations including dates for each:

TYPE OF PROCEDURE	DATE	TYPE OF PROCEDURE	DATE

PATIENT FAMILY HISTORY

Has anyone in your immediate, biological family ever had any of the following?

(Grandparents, Parents, Sisters and/or Brothers)

Heart Disease	☐ Yes	☐ No	**Heart Murmur**	☐ Yes	☐ No
If Yes, Who? _____			*If Yes, Who?* _____		
High Blood Pressure	☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No
If Yes, Who? _____			*If Yes, Who?* _____		
Bleeding Disorders	☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No
If Yes, Who? _____			*If Yes, Who?* _____		
Renal *(Kidney)* **Failure**	☐ Yes	☐ No	**Valley Fever/TB**	☐ Yes	☐ No
If Yes, Who? _____			*If Yes, Who?* _____		
Lung Disease	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
If Yes, Who? _____			*If Yes, Who and Type of Cancer?* _____		

Please inform our office staff of any Living Will, Advanced Directive or Do Not Resuscitate guidelines that you may have and supply our office with a copy for your records.

_____ _____

PATIENT NAME **DATE**

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