Cardiology Consultants of Houston, PLLC **Patient History**

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

Family History

			Diabetes	HTN	Heart Disease	Stroke	Cancer	Mental Diseases	Unknown
Father	Alive Deceased	Age:							
Mother	Alive Deceased	Age:							
Brother(s)	Alive Deceased	Age:							
	Alive Deceased	Age:							
	Alive Deceased	Age:							
Sister(s)	Alive Deceased	Age:							
	Alive Deceased	Age:							
	Alive Deceased	Age:							
Spouse	Alive Deceased	Age:							
Son(s)	Alive Deceased	Age:							
	Alive Deceased	Age:							
Daughter(s)	Alive Deceased	Age:							
	Alive Deceased	Age:							

Medical History (Please check the medical condition you currently have or have had in the past.)

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

Name:	Date of Birth:

Surgical History

Name of Procedure	

Social History

Cigarettes / Tobacco			**Alcohol**			
Do you currently smoke?	Yes	No	Do you drink?	Yes	No	Socially
If yes, how many packs per day?			If yes, how many drinks per day?			
how long have you smoked?			how many days per week?			
If no, how long ago did you quit?			If yes, how long ago did you quit?			
how many packs per day did you smoke?						

Substance Abuse		
Have you ever had or do you currently have a substance abuse (drug) problem?	Yes	No
If yes, what types of drug and frequency of use?		

Caffeine Intake (Please list cups per day)		
Coffee:	Tea:	Sodas: