DEPARTMENT OF
Cardiothoracic & Vascular Surgery

UTHealth
The University of Texas
Health Science Center at Houston
Medical School

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Today's Date

Demographics

First name _____ Last name _____ Date of Birth (mm/dd/yy) _____
☐male ☐female Social Security # _____ Marital Status _____
☐Retired ☐ Disabled ☐Employed Occupation
Address _____ City _____ State _____ Zip _____
Home phone _____ Work phone _____ Mobile phone _____
Email Address

Who may we contact in case of an emergency? _____ *Relationship* _____
Address _____ *City* _____ *State* _____ *Zip* _____
Home phone _____ *Work phone* _____ *Mobile phone* _____
Email Address

Referring physician _____ office phone _____
Primary care physician _____ office phone _____
Other physicians you see regularly _____
Primary health insurance _____ ID# _____ Group# _____
Secondary health insurance _____ ID# _____ Group# _____

Medical and Social History

What is the main reason for your visit today? _____
Do you have any food or drug allergies ☐Yes ☐No Please list: _____
Latex Allergy? ☐ Yes ☐No Iodine/X-ray dye allergy? ☐Yes ☐No
What medications/vitamins/herbal supplements are you taking? _____

How often do you exercise? ☐ Regularly ☐ Occasionally ☐ Sedentary
☐ Unable Explain _____

Have you ever used tobacco ☐Yes ☐ No Type _____ How much? _____
How many years? _____ ☐Quit

Do you drink alcohol ☐Yes ☐No Type _____ How often? _____
How many years? _____
Do you use any street drugs ☐Yes ☐No Type _____ How often? _____
How many years? _____
Are you on dialysis? ☐Yes ☐No Type _____ What days? _____
Date started? _____ Access location _____

Do you currently have or have you had any of the following within the past year:

☐Chest pain	☐Shortness of breath	☐Fatigue
☐Leg pain	☐Dizziness/fainting	☐Difficulty swallowing
☐Abdominal pain	☐Sudden vision changes	☐ Leg/arm swelling
☐Headache	☐Arm pain	☐ Back pain

Mark if you have ever had or currently have the following:

☐ High Blood Pressure	☐ Heart Valve Problems	☐ Non-healing Wound in Legs
☐ Heart Attack	☐ Coronary Artery Disease	☐ Gastric/Duodenal Ulcers
☐ Heart Failure	☐ Carotid Artery Disease	☐ Rectal Bleeding or Black Stool
☐ High Cholesterol	☐ Liver Disease	☐ Peripheral Vascular Disease
☐ Stroke or TIA	☐ Aortic Aneurysm or Dissection	☐ Excessive Bleeding or Bruising
☐ Blood Clots	☐ Asthma	☐ Rheumatic Fever
☐ Diabetes	☐ COPD	☐ Congenital Heart Disorder
☐ Kidney Disease	☐ Thyroid Disorder	☐ Irregular Heart Beat
☐ AIDS/HIV Positive	☐ Blood Transfusions	☐ Seizures or Epilepsy
☐ Cancer	☐ Genetic Disorder	☐ Pacemaker or Defibrillator

Do you have any other medical condition you are being treated or have been treated for not listed above? ☐Yes ☐No If yes please list: _____

What surgical procedure have you had? (list all procedures, and dates if possible)

Family History (please list cardiac/vascular history such as heart attack, heart valve disorder, bypass surgery, aneurysms, heart failure, stroke, diabetes, hypertension, stents in leg/heart, etc.)

Please list recent testing with dates: (CT scan, stress test, EKG, echocardiogram, heart cath, ultrasound, etc) _____

Have you ever had general anesthesia: ☐ Yes ☐ No
If yes, was there an adverse reaction? _____