California Vascular Care

*An affiliate of* EAST BAY CARDIOVASCULAR & THORACIC ASSOCIATES

# Patient Health History

Name: _____ Age: _____ Height: _____ Weight: _____ Sex: M / F

Date of Last Physical Exam: _____ Date of Last EKG: _____ Location: _____

| Previous Operations | When & Where | Type of Anesthesia (General, Nerve Block, Spinal or Epidural) | Complications |
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**Family History of Anesthetic Complications?** ☐ NO ☐ YES (describe) _____

Check below if you now have or have ever been treated for any of the following medical conditions. Leave the box blank if not applicable.

| | Heart/Vascular | | Nerve Disease | | Bleeding Disorders | | Dental/Vision/Hearing |
|---|---|---|---|---|---|---|---|
| ☐ | Heart Attack | ☐ | Stroke | ☐ | Easy Bruising | ☐ | Dentures/Partial Plates |
| ☐ | Heart Failure | ☐ | Transient Ischemic Attack | ☐ | Nosebleeds | ☐ | Capped Teeth |
| ☐ | Coronary Artery Disease | ☐ | Numbness/Weakness | ☐ | Blood Transfusion | ☐ | Chipped Teeth |
| ☐ | Angina/Chest Pain | ☐ | Seizures | ☐ | Anemia/Clotting Disorders | ☐ | Loose Teeth |
| ☐ | Abnormal EKG | ☐ | Headaches/Migraines | | **Thyroid/Liver/Kidney/GI** | ☐ | Gum Disease |
| ☐ | Arrhythmia/Palpitations | ☐ | Psych.Illness/ADD/Bipolar | ☐ | Hypothyroid/Hyperthyroid | ☐ | Contact Lenses/Glasses |
| ☐ | Pacemaker | | **Respiratory/Lung** | ☐ | Hepatitis/Cirrhosis | ☐ | Body Piercings |
| ☐ | Internal Cardiac Defibrillator | ☐ | Asthma | ☐ | Diabetes Type I/II | ☐ | Hearing Aid |
| ☐ | Murmur/Valve Disease/MVP | ☐ | Bronchitis | ☐ | Kidney Disease | | **Other** |
| ☐ | Exercise Limitation | ☐ | COPD/Emphysema | ☐ | End Stage Renal Disease | ☐ | Prosthesis |
| ☐ | Peripheral Vascular Disease | ☐ | Pneumonia | ☐ | Dialysis | ☐ | Motion Sickness/Fainting |
| ☐ | High Blood Pressure | ☐ | Tuberculosis | ☐ | Gout | ☐ | MRSA |
| | **Bone/Joint Problems** | ☐ | Abnormal Chest X-Ray | ☐ | Hiatal Hernia | ☐ | Drug/Substance Abuse |
| ☐ | Arthritis/Osteoporosis | ☐ | Sleep Apnea | ☐ | Acid Reflux/GERD/Ulcers | ☐ | Recent Infectious Exposure |
| ☐ | Neck/Back Problems | ☐ | Daytime Sleepiness | ☐ | Irritable Bowel/Colitis | ☐ | AIDS/HIV |
| ☐ | Steroid/Cortisone Use | ☐ | Heavy Snoring | ☐ | Diverticulosis | ☐ | Cancer |

Other medical problems: _____

Can you walk up two flights of stairs without difficulty? ☐ YES ☐ NO - If not, explain: _____

Do you drink alcohol? ☐ None ☐ Occasionally ☐ Daily – Amount _____

Do you exercise regularly? ☐ NO ☐ YES – If yes, how often and how long do you exercise? _____

Are you pregnant? ☐ YES ☐ NO - Might you be pregnant? _____ Date of last menstrual period: _____

How much do/did you smoke per day? _____ How many years? _____ When did you quit? _____

Do you have an Advanced Directive (Living Will or Durable Power of Attorney for Health Care)? ☐ YES ☐ NO

**Date:** _____**Time:** _____ (AM/PM) **Patient Signature:** _____