Golden Empire Cardiology

Personal History Form

Please Fill Completely. Please Print.

Today's Date ________ / ________ / ________ Date of Birth ________ / ________ / ________

Full Name **(First, Middle, Last)** ____

Drug Allergies ____

Referred By ____

Surgeries ____

Past Medical Histoy

Please read through the following list and check any problems that you may currently have or have experienced in the past.

Bones, Joints & Muscles ☐ Arthritis ☐ Bursitis ☐ Gout Chronic Back Pain

Blood System ☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Blood Clots ☐ Abnormal Bleeding

Endocrine System ☐ Goiter ☐ Thyroid Problems ☐ Diabetes ☐ Adrenal Problems

Brain & Nervous System ☐ Headache ☐ Seizure Disorders ☐ Strokes ☐ TIA ☐ Paralysis

Heart & Circulatory System ☐ Chest Pain ☐ Chest Pressure ☐ High Blood Pressure ☐ Palpitations

☐ Heart Murmur ☐ Phlebitis ☐ Congestive Heart Failure

Lungs & Respiratory System ☐ Allergies ☐ Valley Fever ☐ Asthma ☐ Emphysema ☐ COPD ☐ Pneumonia ☐ TB

Digstive System ☐ Ulcers ☐ Colits ☐ Gallbladder ☐ Hiatal Hernia ☐ Hepatitis ☐ Pancreatitis ☐ Cirrhosis

Urinary Tract ☐ Kidney Problems ☐ Kidney Stones ☐ Recurrent Bladder Infections ☐ Renal Failure

☐ **Cancer, Tumor or Cysts that required treatment** ☐ **AIDS or ARC** ☐ **Previous Rheumatic Fever**

☐ **Nervous, Mental, Emotional, Behavioral or Psychological Problems** ☐ **Depression**

Family & Social Histoy

Please include strokes, heart attacks and high blood pressure for the following family members.

Father ______________________ Mother ______________________

Siblings ____

Other relatives with heart disease ____

Occupation ____________________________________ Retired? ☐ **Yes** ☐ **No**

Marital Status ____

Are you a smoker? ☐ **Yes** ☐ **No** Did you ever smoke? ☐ **Yes** ☐ **No** Year you stopped smoking ______________

Number of packs per day that you smoke or used to smoke __________ Total number of years that you smoked __________

Amount of alcoholic beverage consumed per week ____

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