San Diego Cardiovascular Associates
320 Santa Fe Drive #204
Encinitas, CA 92024

Confidential Medical History

DATE: ____/____/____

Name:____DOB:__________

Please answer all questions, do not leave any blank spaces. No part of this form's contents will be released without your signed consent.

Chief Complaint: **Date of onset:**

1)
2)
3)
4)
5)

General Health:

Do you consider yourself basically healthy now? __________

When did you last feel well? __________________________

Has there been a big change in your weight in the past year? ________

(if yes, indicate date and amount of loss/gain) _________________

Have you been having a fever lately? __________

Do you usually sleep well? ________ How many hours? _____________

Have you been followed by a physician on a regular basis? _________

(if yes, list name and address: ______________________________________

____

What do you do in your spare time? ______________________________________

In the past year, has there been any change in your: Marital Status: ______ Work or Job: ______ Residence: _______ Spare time activity: ________ Physical Activity: ______ Drinking habits: ______ Smoking habits: _______

Past Medical and Surgical History:

List all surgeries you have had, indicating the nature of operation and where and when it was done.

Operation:	Hospital & City:	Date:
1)		
2)		
3)		
4)		
5)		

List any other reasons for hospitalization (illness, accident, etc.)

Hospitalization:	Hospital & City:	Date:
1)		
2)		
3)		
4)		
5)		

Have **you** ever experienced trouble with any of the following:
Breathing while lying down? ____Blackouts?____Circulation in legs? _____
Regular heartbeat ? ______Heart Murmur? ______ Breathing while walking or other excertion? _________

Have **any blood relatives** had any of the following: (if so, indicate relationship)
Diabetes: _________ Cancer: __________ Blood Disease: ________
Rheumatoid arthritis: _____________ Thyroid Disease: _____________
Heart attack/bypass surgery: ________________ Alcoholism: ___________
High Blood Pressure (hypertension): ___________ Epilepsy:_____________
Cholesterol problems: ________________ Psychiatric Disease: __________
Nervous Breakdown: ________________ Other: ____________________

Have **you** ever experienced any of the following:
Cancer: _______ Anemia: ______ Diabetes: ______ Alcoholism: _____
Bleeding Tendency: ______Venereal Disease: ______Drug dependence:_____
Blood Transfusion: ______ AIDS: ______Any obscure or unusual disease:____
High Blood Pressure: ______High Cholesterol: _______ Smoking:________
Rheumatic Fever: __________ Other: ______________________________

Current Medications:
List all medications you are currently taking, including the name, strength, dosage, and how often taken.

Name of Medication: Strength: How often taken: Dose:
1)
2)
3)
4)
5)

Are you allergic to any medications? If so please list:
1)
2)
3)
4)

Personal History:

Are you married? _____How long? _____ Children? Y / N How many?______
Do you have a pet? _____________ What kind? ________________
What is your current occupation? ____________________________________
Do you enjoy your work/retirement? ___________

Signature: ____ Date: ________