Cardiology Services of East Texas

History and Physical

Name:_____**DOB:**_____/_____/_____ **Date:**_____

Height _____**Ft'** _____**In" Reason For Visit:**_____

Medical History

Atrial Fibrillation(afib):	Y	N	Diabetes:	Y	N
Arrhythmia:	Y	N	Heart Murmur:	Y	N
Cancer:	Y	N	Hypertension(HTN):	Y	N
Congestive Heart Failure(CHF):	Y	N	High Cholesterol:	Y	N
Coronary artery Disease(CAD):	Y	N	Kidney Disease:	Y	N
Stroke:	Y	N	Other:_____		

Do you currently use tobacco? Y N :Type_____ How much? _____/Day
Have you ever used tobacco? Y N :Type_____ How much? _____/Day
Do you consume alcohol? Y N :Frequency _____

Surgical History

Coronary artery bypass graft: Y N
Catheterization: Y N
Stent Placement: Y N
ICD/Pacemaker: Y N
Other:_____

Family History *(Check all that apply)*

Relation	Hypertension	Diabetes	Coronary Artery Disease	Stroke	Myocardial Infarction	Congestive Heart Failure	Atrial Fibrillation	Cancer & Type	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐_____	☐_____
Father	☐	☐	☐	☐	☐	☐	☐	☐_____	☐_____
Brother	☐	☐	☐	☐	☐	☐	☐	☐_____	☐_____
Sister	☐	☐	☐	☐	☐	☐	☐	☐_____	☐_____
Other	☐	☐	☐	☐	☐	☐	☐	☐_____	☐_____

***Continued on back

Cardiology Services of East Texas

Allergies to Medications: _____

Current Medications:

Medication Name	Dosage	Times Per Day

Pharmacy: _____ **City: _____**

_____

{Patient or Responsible Party's Signature}