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CONFIDENTIAL HEALTH HISTORY

Name: ____ Date of Birth: _______________________________

Reason you are here: ____

If for chest discomfort, when does it occur? ____

____

Your Cardiac History:

Treadmill test	yes	no
Palpitations	yes	no
Rapid Heartbeat	yes	no
Poor Circulation	yes	no
Shortness of breath	yes	no
Swelling	yes	no
High Blood Pressure	yes	no
Heart Murmur	yes	no
Rheumatic Fever	yes	no
Smoker	yes	no
Obesity	yes	no
Diabetes	yes	no
High Cholesterol	yes	no

Family Cardiac History: Has anyone in your family been diagnosed with heart disease, had a heart attack or diagnosed with high cholesterol? If yes, explain:

____

____

____

Has anyone in your family died of heart disease? If yes, explain:

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Other Health History: Have you ever had surgery or been hospitalized? If yes, explain____
____
____

Allergic to iodine yes no Shellfish yes no Penicillin yes no

Abdominal pain	yes	no	Asthma	yes	no
Blackout	yes	no	Constipation	yes	no
Cough	yes	no	Dizziness	yes	no
Emphysema	yes	no	Excessive thirst	yes	no
Excessive hunger	yes	no	Fainting	yes	no
Head injury	yes	no	Headaches	yes	no
Hearing loss	yes	no	Heartburn	yes	no
Hepatitis	yes	no	Liver/Gallbladder	yes	no
Numbness	yes	no	Painful Urination	yes	no
Phlebitis	yes	no	Pain in legs	yes	no
Pneumonia	yes	no	Seizures	yes	no
Sinus Problems	yes	no	Varicose Veins	yes	no
Vision loss	yes	no	Weight gain/loss	yes	no
Alcohol	yes	no	Quit smoking	yes	no
Recreational drugs	yes	no	Caffeine	yes	no

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List or attach a list of all medications you are currently taking including over the counter:

1.____
2.____
3.____
4.____
5.____
6.____

Any additional information you would like to add:

____
____
____
____
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____
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____
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