Patient Name:_____ Date:_____ Accnt#:_____

I. Past Medical History

Yes	No		Yes	No	
___	___	Heart Disease	___	___	Gastrointestinal
___	___	Diabetes	___	___	Kidney Disease
___	___	High Cholesterol	___	___	Stroke, TIA
___	___	Hypertension (high blood pressure)	___	___	Bleeding disorder
___	___	Lung Disease	___	___	Liver Disease

Other (please specify):_____

II. **Past Surgeries**:

1._____
2._____
3._____
4._____

III. **Present Medications** (include dosage & frequency)

1._____
2._____
3._____
4._____
5._____

IV. **Medication Allergies**:

1._____
2._____
3._____
4._____

IV. **Family History**. Is there a family history of heart disease?
If yes, please explain below.