Cardiac Procedure History

Have you ever had any of the following?

Stress Test: Y / N

When:______________________________

Heart Catheterization: Y / N

When: ______________________________

Heart Ultrasound (Echo): Y / N

When: ______________________________

Stent/Other Coronary therapy: Y / N

When: ______________________________

Coronary Angiography: Y / N

When: ______________________________

Valve Surgery: Y / N

When: ______________________________

Electrophysiology Study: Y / N

When: ______________________________

Pacemaker or Defibrillator: Y / N

When: ______________________________

Other: ______________________________

When: ______________________________

Other: ______________________________

When: ______________________________

Healthy Heart Cardiology
Dr. Mohamed Rahman M.D.
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Phone: (903) 251-3252 Fax: (903) 487-2610

Medical History:

Please specify any other illness or medical conditions you have now or have had in the past:

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Please list any operations or injuries:

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If you are a woman, are you passed menopause? Y / N

At what age?

Do you take estrogen replacement? Y / N

Are you taking birth control pills? Y / N

Allergies:

Are you allergic to any medications: Y / N

Please list any medications you can not tolerate and what happens when you take them:

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Medical History Continued

Please circle any symptoms you are having now or had recently:

Constitutional:	Fever	Chills	Fatigue
Respiratory:	Shortness of Breath	Wheezing	Cough
Gastrointestinal:	Heartburn	Diarrhea	Constipation
Musculoskeletal:	Muscle aches	Muscle tenderness	Muscle Cramps
Dermatological:	Skin Ulcers	Rash	
Neurological:	Dizziness	Headaches	
Endocrinological:	Bleeding	Easy Bruising	
Psychiatric:	Anxiety	Depression	

Please List any other symptoms you are having now or have had recently:

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Medical History Continued

Medications:

Please list your medications including non-prescription drugs, supplements, and any herbal, naturopathic, or homeopathic products/remedies. Include dose and strength as applicable.

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Family History:

Coronary disease, Angina, Heart Attack or Cardiac Arrest? Y / N

If yes, did your father, brother, or sons have it before the age of 55: Y / N

If yes, did your mother, sisters, or daughters have it before the age of 55: Y / N

Please give age AND cause of death, if known for:

Family Member	*Cause of Death*	*Age*
Mother:		
Father:		
Brother(s)/ Sister(s):		