BAY AREA HEART
Cardiovascular Center of Excellence

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HISTORIES

PATIENT NAME:_____ **DOB:**_____

Family History:

If any of your family members listed suffer from these Medical Histories, please fill in bubble as appropriate.

Father: O Alive O High Blood Pressure O Diabetes O Heart Disease
O High Cholesterol O Cancer O Stroke O None

Mother: O Alive O High Blood Pressure O Diabetes O Heart Disease
O High Cholesterol O Cancer O Stroke O None

Siblings: O Alive O High Blood Pressure O Diabetes O Heart Disease
O High Cholesterol O Cancer O Stroke O None

Please fill in all bubbles regarding your own medical history, surgical history, and hospitalizations. If not listed, please write in the space provided.

Your Past Medical History

Anemia	O Yes	Asthma	O Yes	Chest pain	O Yes
Anxiety	O Yes	Cardiac arrhythmia	O Yes	Cardiac murmur	O Yes
Enlarged heart	O Yes	Congestive heart failure	O Yes	Chronic cough	O Yes
Deep Vein Thrombosis	O Yes	Depression	O Yes	Diabetes	O Yes
Elevated cholesterol	O Yes	Heart Disease	O Yes	Heartburn	O Yes
High blood pressure	O Yes	Hyperthyroidism	O Yes	Hypothyroidism	O Yes
Kidney Disease	O Yes	Stroke	O Yes		

Other Medical History not listed_____

Your Surgical History

Appendix removed	O Yes	Bowel surgery	O Yes	Cataract removal	O Yes
Gall bladder removed	O Yes	Open Heart Bypass	O Yes	Hernia Repair	O Yes
Hysterectomy	O Yes	Pacemaker	O Yes	Tonsils removed	O Yes
Back surgery	O Yes				

Other Surgeries not listed_____

Hospitalizations

Heart Attack	O Yes	Anemia	O Yes	Atrial fibrillation	O Yes
Chest pain	O Yes	Congestive heart failure	O Yes	Shortness Of Breath	O Yes

Other Hospitalizations not listed_____