Florida Heart & Vascular Care at Northwest
MEDICAL HISTORY

Name: _____ D.O.B. _____ Date: _____

Please list your medications (including dosages):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

1. _____ 2. _____ 3. _____

Do you have any allergies to latex? ❑ Yes ❑ No

MEDICAL PROBLEMS

		YES	NO			YES	NO
1.	Heart Attack	❑	❑	12.	Thyroid Disease	❑	❑
2.	High Blood Pressure	❑	❑	13.	Stomach Ulcers	❑	❑
3.	Angina	❑	❑	14.	Hiatal Hernia	❑	❑
4.	High Cholesterol	❑	❑	15.	Cancer/Leukemia	❑	❑
5.	Diabetes	❑	❑	16.	Emphysema/Bronchitis Asthma	❑	❑
6.	Heart Murmur/Valve Problem	❑	❑	17.	Pneumonia	❑	❑
7.	Congestive Heart Beat	❑	❑	18.	Anemia	❑	❑
8.	Irregular Heart Beat	❑	❑	19.	Tuberculosis	❑	❑
9.	Pericarditis	❑	❑	20.	Liver/Gallbladder Disease	❑	❑
10.	Stroke	❑	❑	21.	Colitis	❑	❑
11.	Kidney Disease	❑	❑				

SYMPTOMS

		YES	NO			YES	NO
1.	Chest Pain/Discomfort	❑	❑	5.	Light-headedness	❑	❑
2.	Shortness of Breath	❑	❑	6.	Fainting Spells	❑	❑
3.	Palpitations/Skipped Beats	❑	❑	7.	Swollen Legs	❑	❑
4.	Dizziness	❑	❑				

SURGICAL PROCEDURES

1. Bypass Surgery _____ Date: _____
2. Coronary _____ Date: _____
3. Pacemaker _____ Date: _____
4. Defibrillator _____ Date: _____

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