Name _____ Date _____ D.O.B._____

Age _____ Height _____ Weight _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

General: (circle yes or no)		
High Blood Pressure	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Type of Cancer		
Ulcerative colitis	Yes	No
Crohn's Disease	Yes	No
Lupus	Yes	No
Gout	Yes	No
Cardiac		
Angina	Yes	No
Pacemaker	Yes	No
Chest tightness	Yes	No
Heart Attack	Yes	No
Sleep on more than one pillow	Yes	No
Shortness of breath at night	Yes	No
Lungs		
Shortness of breath	Yes	No
Chronic cough	Yes	No
Cough up blood	Yes	No
Cough up mucous	Yes	No
Gastrointestinal		
Diarrhea	Yes	No
Constipation	Yes	No
Blood per rectum	Yes	No
Genitourinary		
Problems urinary	Yes	No
Blood in urine	Yes	No
Painful urination	Yes	No
Kidney problems	Yes	No
Neuro		
Stroke	Yes	No
Memory Loss	Yes	No
Dizziness	Yes	No
Temporary paralyzed	Yes	No
Vision loss in either eye	Yes	No
Passing out	Yes	No
Vascular		
Legs cramp with walking	Yes	No
At what distance		
Gangrene	Yes	No

List any Surgeries and Date:

_____

_____

_____

_____

Did you have any problems w/ anesthesia

Yes No

Please List All Medications:

_____

_____

_____

_____

_____

Do you have any allergies? Yes No

If so, please list: _____

_____

Please circle if you take one of these medications:

Glucophage	Yes	No
Coumadin	Yes	No
Plavix	Yes	No
Ticlid	Yes	No

Do you smoke? Yes No

If yes, PPD _____ how long _____

Do you drink? Yes No

If yes, how much _____ how long ____

Is there a family history of heart disease?

Yes No

If yes, who? _____

Present complaint: _____

_____

_____

List all Physicians: _____

_____

_____

Have you or any family members ever seen or had surgery by a CVT doctor? What procedure and whom?

_____