TEXAS INSTITUTE OF CARDIOLOGY, P.A.

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Patient Name: **Date:**

SYMPTOMS/REASON FOR VISIT:

MEDICAL PROBLEMS (PLEASE CHECK ALL THAT APPLY)

	CONDITION	YEAR		CONDITION	YEAR
	Angina			Colitis	
	Coronary Artery Disease			GERD	
	Heart Attack			Stomach Ulcer	
	Heart Failure (CHF)			Liver Disease	
	Heart Valve Disease-Type			Renal Insufficiency/Kidney Disease/Dialysis	
	Bypass Surgery			Gout	
	Angioplasty			Arthritis	
	Peripheral Vascular Disease			Migraine Headaches	
	Irregular Heart Rhythm-Type			Seizures	
	High Cholesterol			Stroke	
	High Blood Pressure			Anemia	
	Thyroid Disease Hyper Hypo			Bleeding/Clotting Disorder	
	Diabetes Type I Type II			Cancer Type	
	Sleep Apnea			AIDS/HIV	
	Tuberculosis			Depression/Anxiety	
	Asthma			Bipolar Disorder	
	Lung Disease (COPD)			Other	

PREVIOUS MEDICAL HISTORY

Type and Place of Surgery/Hospitalization	YEAR

PHYSICIANS YOU FOLLOW WITH AND FOR WHAT REASON

Patient Name:	
SOCIAL HISTORY	
Do you exercise Regularly?	**Type of Exercise:** **How often?**
TOBACCO USE (Cigarettes, cigars, pipes, smokeless tobacco, ecigs): **Never I quit (Year:) I still smoke ( ) Packs a day ( ) How long do/did you smoke ( )** **Smokeless Tobacco Number of cans ( ) How long ( )**	
ALCOHOL USE	
How often do you drink: Never Occasionally Socially Daily Weekly **Number of drinks per week ( ) Beer Red Wine White Wine Liquor**	
ALLERGIES (List all medication or food allergies, as well as your reaction):	

FAMILY MEDICAL HISTORY

	Age	**Medical Condition**	**Live/Died**	**Cause**
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brothers				
Sisters				
Sons				
Daughters				