Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Patient History

Today's Date: _____

Name: _____ DOB: _____ Medical Record #: _____

How did you hear about us? _____

History of Present Illness

Reason for visit: _____

_____

Have you ever had a cardiac cathederization? ◯ Yes ◯ No

If yes, when and where: _____

	Allergies to drugs, dyes, or others	**Describe your experience**
1		
2		
3		

	Past Surgeries	**Reason**
1		
2		
3		

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List of Medications

Name: _____ DOB: _____ Medical Record #: _____

Pharmacy Name: _____ Address: _____

Phone #: _____

Please include all prescription medications, over-the-counter medications, vitamins, and herbal supplements. Please update and bring in this form to every office visit.

	Name of Medication	Dosage	How many times per day?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

Past Medical History

Please answer if you have **already been diagnosed** with any of the following conditions in the past. **Answer ONLY the ones that apply.**

Condition	When did it start	Details
Diabetes Mellitus		
Anemia		
Arthritis		
Thyroid Disorder (please specify)		
Hernia		
Cancer (please explain)		
HIV (AIDS)		
High Blood Pressure		
Irregular Heart Beats (arrhythmias)		
Syncope (fainting)		
Rheumatic Fever		
Heart Attack		
Heart Failure		
Heart Murmur		
Cardiomyopathy		
Carotid Artery Disease (CAD)		
Congestive Heart Failure (CHF)		
New Heart Valves		
Stents In Heart		
Pacemaker/Defibrillator		
Past Heart Surgery		
Heart Transplant		
Aneurysm		

PAD (blockages in leg arteries)		
Pain in Legs When Walking		
DVT (clots in leg veins)		
Stents In Legs		
Leg Vein Ablation(s)		
Asthma		
Chronic Obstructive Pulmonary Disease		
Pulmonary Embolism (clot in the lungs)		
Tuberculosis		
Sleep Apnea		
Kidney Disease		
Dialysis(long term)		
Kidney Transplant		
Hepatitis		
Liver Disease		
GERD (acid reflux)		
Peptic/Stomach Ulcers		
Bleeding easily		
Clotting easily		
Convulsions (Seizures)		
High Cholesterol		
Stroke/TIA		
Others:		

Family History

Please check below any of the Medical Illness that may relate to your family members

	Father	Mother	Brother	Sister	Other
Heart Disease	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	

Social History

Are you currently working? ○ Yes ○ No If yes, occupation _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Windowed ○ Separated

Do you exercise? ○ Yes ○ No If yes, how many times per week? _____

Caffeine Use (tea, coffee, soda) ○ Everyday ○ Occasionally ○ Never

Alcohol History:

Do you currently drink alcohol? ○ Everyday ○ Occasionally ○ Never

For how long? _____ How much per week? _____

What type of alcohol? ☐ Wine ☐ Beer ☐ Liquor

Smoking & Tobacco History:

Have you ever used tobacco? ○ Currently ○ In the past ○ Never

If currently using, which type? ☐ Cigarette ☐ E-Cigarette ☐ Cigar ☐ Pipe ☐ Chew/Dip

How many packs/amount per day? _____ At what age did you start? _____

If former user: Age started _____ Age stopped _____ How many packs/amount per day? _____

Drug History:

Do you currently use any recreational drugs? ○ Yes ○ No If yes, for how long? _____

Please explain which drug(s) you use _____

Have you ever used any recreational drugs in the past? ○ Yes ○ No If yes, for how long? _____

Please explain which drug(s) you use _____

Menstrual History (Females):

Last Menstrual Period: _____ Age of Menopause: _____

Sexual History:

Are you sexually active? ○ Yes ○ No

Review of Systems

Please check the symptom(s) you are **currently** experiencing

General

- ☐ Fever
- ☐ Chills
- ☐ Loss of appetite
- ☐ Generalized weakness
- ☐ Fatigue
- ☐ Weight gain
- ☐ Weight loss
- ☐ Night sweats
- ☐ Difficulty sleeping

Other: _____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Poor appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Loose stools (diarrhea)
- ☐ No stools (constipation)
- ☐ Yellow colored eyes or skin
- ☐ Changes in bowel habits
- ☐ Bright red blood in stools
- ☐ Dark colored or black stools
- ☐ Hemorrhoids

Other: _____

Eyes

- ☐ Blurry vision
- ☐ Double vision
- ☐ Wear glasses

Other: _____

Ear/Nose/Throat

- ☐ Difficulty hearing
- ☐ Ringing in ear(s)
- ☐ Loss of hearing
- ☐ Sore throat

Other: _____

Cardiovascular

- ☐ Chest pain or discomfort
- ☐ Heart racing/pounding Irregular/funny heartbeat
- ☐ Dizziness/feeling lightheaded
- ☐ Fainting
- ☐ Shortness of breath on rest
- ☐ Shortness of breath with activity
- ☐ Shortness of breath when lying flat
- ☐ Waking up at night from shortness of breath
- ☐ Blue discoloration of skin
- ☐ Pain in leg(s) when walking
- ☐ Swelling of leg(s)

Other: _____

Neurological

- ☐ General body weakness
- ☐ Weakness in a specific area
- ☐ Numbness
- ☐ Changes in sensations (ex: tingling)
- ☐ Shaky hands
- ☐ Difficulty concentrating
- ☐ Difficulty with coordination
- ☐ Daytime sleepiness
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Feeling lightheaded
- ☐ Seizures

Other: _____

Genitourinary

- ☐ Pain/burning during urination
- ☐ Hesitancy during urination
- ☐ Urgency to urinate
- ☐ Blood in urine
- ☐ Frequent urination at night
- ☐ Urine dribbling
- ☐ Decreased libido
- ☐ Enlarged Prostate
- ☐ Changes in breast(s)

Other: _____

Respiratory

- ☐ Long standing cough
- ☐ Wheezing shortness of breath on rest
- ☐ Shortness of breath with activity
- ☐ Snoring
- ☐ Gasping for air during sleep
- ☐ C-Pap use
- ☐ Oxygen use
- ☐ Coughing up blood

Other: _____

Psychiatric

- ☐ Feeling jittery/ nervous
- ☐ Difficulty remembering
- ☐ Changes in mood
- ☐ Racing thoughts

Other: _____

Musculoskeletal

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back or neck pain
- ☐ Morning stiffness
- ☐ Muscle cramping/ tightening
- ☐ Limitation of motion

Other: _____

Endocrine

- ☐ Feeling hotter than usual
- ☐ Feeling colder than usual
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive urination

Other: _____

Hematologic/Lymphatic

- ☐ Bleeding easily
- ☐ Bruising easily
- ☐ Lumps/bumps/masses

Other: _____