Past Medical History

Name: ______________________________ Date Of Birth: ______________________________

Warfarin Management	Yes No	**Managed by:**		Chronic Obstructive Pulmonary Disease	Yes No	
Heart Attack/MI	Yes No	**Date:**		Asthma	Yes No	
Coronary Artery Disease	Yes No			Other Pulmonary Disease	Yes No	
Arrhythmia	Yes No			Cancer	Yes No	
Hyperlipidemia	Yes No			Gastrointestinal Disease	Yes No	
Diabetes	Yes No			Genitourinary Disease	Yes No	
Hypertension	Yes No			Hematologic Disease	Yes No	
CVA	Yes No			Orthopedic History	Yes No	
Congenital Heart Disease	Yes No			Arthritis	Yes No	
Peripheral Arterial Disease	Yes No			Kidney Disease	Yes No	**Managed by:**
Aortic Aneurysm	Yes No			Liver Disease	Yes No	
Carotid Disease	Yes No			Neurologic Disorder	Yes No	
Deep Vein Thrombophlebitis	Yes No	**Date:**		Sleep Disorder	Yes No	**Managed by:**
Congestive Heart Failure	Yes No			Thyroid Disease	Yes No	
Valvular Heart Disease	Yes No			Dialysis	Yes No	
				Other		

Do you smoke or use smokeless tobacco? Current Smoker Previous smoker Non-Smoker
(**Circle one**)

If you use any form of tobacco, how frequently? ____

If you use to **used** any form of tobacco when did you quit? ______________________________________

Do you exercise regularly? Yes No How much? ______________________________
(Circle one)

Do you drink alcohol? Yes No How much? ________________________________
(Circle one)

Do you drink caffeine? Yes No How much?______________________________
(Circle one)

Does anyone in your family have a history of **cardiac problems**? Please list family member and disease:

Relationship (example: Mother, Grandfather)	**Type** (example: Stroke, Heart Attack, Other)