Medical History

Cottage Grove Cardiology, P.C.
Specializing in Cardiovascular Medicine

Account #:

Patient Name: _____ Date: _____

Date of Birth: _____

CARDIAC (HEART PROBLEMS)

High Blood Pressure	Yes ( ) No ( )
Heart Attack	Yes ( ) No ( )
Bypass or Stent	Yes ( ) No ( )
Chest Pain	Yes ( ) No ( )
Palpitations	Yes ( ) No ( )
Congestive Heart Failure	Yes ( ) No ( )
Abnormal EKG	Yes ( ) No ( )
Murmur	Yes ( ) No ( )
Rheumatic Fever	Yes ( ) No ( )
Pacemaker or ICD	Yes ( ) No ( )

FAMILY HISTORY **CIRCLE ALL THE APPLY**

Polyps	Yes ( ) No ( )	Father/Mother/Sibling
Liver Disease	Yes ( ) No ( )	Father/Mother/Sibling
Ulcers	Yes ( ) No ( )	Father/Mother/Sibling
Coliti/Crohn's	Yes ( ) No ( )	Father/Mother/Sibling
Diabetes	Yes ( ) No ( )	Father/Mother/Sibling
Heart Disease	Yes ( ) No ( )	Father/Mother/Sibling
High Cholestrol	Yes ( ) No ( )	Father/Mother/Sibling
High Blood Pressure	Yes ( ) No ( )	Father/Mother/Sibling
Cancer	Yes ( ) No ( )	Father/Mother/Sibling

HEPATIC (LIVER PROBLEMS)

Jaundice	Yes ( ) No ( )
Hepatitis A, B or C	Yes ( ) No ( )
Cirrhosis	Yes ( ) No ( )
Elevated Enzymes	Yes ( ) No ( )

RENAL (KIDNEY PROBLEMS)

Insufficiency	Yes ( ) No ( )
Chronic Failure	Yes ( ) No ( )
Dialysis	Yes ( ) No ( )

IMMUNE SYSTEM

HIV/Aids	Yes ( ) No ( )

ENDOCRINE

Diabetes	Yes ( ) No ( )
Thyroid	Yes ( ) No ( )

CANCER

Colon	Yes ( ) No ( )
Breast	Yes ( ) No ( )
Other	Yes ( ) No ( )
If yes, where?	

GASTROENTEROLOGY/STOMACH

Constipation	Yes ( ) No ( )
Diarrhea	Yes ( ) No ( )
Trouble Swallowing	Yes ( ) No ( )
Colon Polyps	Yes ( ) No ( )
Colitis/Crohn's	Yes ( ) No ( )
Diverticulosis	Yes ( ) No ( )
Ulcers	Yes ( ) No ( )
Gallstones	Yes ( ) No ( )

HEME (BLOOD)

Anemia	Yes ( ) No ( )
Sickle Cell	Yes ( ) No ( )
Clotting Problems	Yes ( ) No ( )
Blood Transfusion	Yes ( ) No ( )
Easy Bruising	Yes ( ) No ( )

NEUROLOGICAL

Seizures	Yes ( ) No ( )
Stroke	Yes ( ) No ( )
Syncope/Dizziness	Yes ( ) No ( )
Weakness	Yes ( ) No ( )
Paraylsis	Yes ( ) No ( )

PLEASE SEE REVERSE SIDE

Do you drink alcoholic beverages? Yes ( ) or No ( )

If so, how much? DAILY _____ WEEKLY _____ MONTHLY _____

Do you smoke? Yes ( ) or No ( )

If so, how long have you been a smoker? _____ How many cigarettes a day? _____

Have you ever been hospitalized? If so, when and what for?

_____

_____

_____

Are there any other medical problems we should be aware of?

_____

_____

Do you have any allergies:

_____

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Are you taking any medications at this time?

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