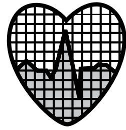

Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

Diagnostic & Interventional Cardiology
Diplomate American Board of Internal Medicine,
Cardiovascular Disease and Interventional Cardiology

HEALTH HISTORY FORM

Today's Date: _____ / _____ / _____ DOB: _____ / _____ / _____ Ht: _____ Wt: _____ lb

NAME: (Last) ________________________ (First) ____________________ (MI) _____ Age: _____

Referring Physician: ______________________ Onset of symptoms: ______________________

Past Medical History (Check all that apply):

- ❑ Glaucoma or cataracts
- ❑ Sleep apnea
- ❑ Heart Attack
- ❑ Heart Failure
- ❑ Cardiac Cath Date: __________
- ❑ Pacemaker Date: ___________
- ❑ GERD
- ❑ Diabetes
- ❑ Stroke (including mini-strokes)
- ❑ Emotional disorders
- ❑ Hormone replacement therapy
- ❑ COPD
- ❑ High cholesterol
- ❑ Irregular Heartbeat
- ❑ Swelling of legs/feet
- ❑ Angioplasty/Stent Date: ________
- ❑ AICD Date:
- ❑ Hepatitis
- ❑ Thyroid problems
- ❑ Parkinson's
- ❑ Cancer
- ❑ Osteoarthritis
- ❑ Asthma
- ❑ Heart Murmur
- ❑ Peripheral Arterial Disease
- ❑ Valve disease
- ❑ Aortic aneurysm
- ❑ Kidney insufficiency/failure
- ❑ Benign prostatic hypertrophy
- ❑ Alzheimer's
- ❑ DVT / Pulmonary emboli
- ❑ Rheumatoid arthritis

❑ Do you follow any special diet? If yes, please check: low sodium ___ diabetic ___ renal ___ low fat ___ low cholesterol ___

Past Surgical History:

______________________ Date:______________ ______________________ Date:______________

______________________ Date:______________ ______________________ Date:______________

______________________ Date:______________ ______________________ Date:______________

Risk Factors:

Type of tobacco ____________________ amount ____________ per day/week x _______ years

Alcohol use _______ per day/week/month x _____ years

Recreational drug use _______ per day/week/month x _____ years

Immediate family history of heart disease: ____

____

PERSONAL MEDICATION RECORD

Fold this form and keep it in your wallet or purse | Date form started:

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	
Primary Physician Contact number:	

Allergic To /Describe Reaction:	Allergic To /Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for taking / Doctor Name