DEPARTMENT OF
Cardiothoracic & Vascular Surgery

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UTHealth
The University of Texas
Health Science Center at Houston
Medical School

Today's Date

Demographics

First name ____________ Last name ____________ Date of Birth (mm/dd/yy) ____________

☐male ☐female Social Security # ____________ Marital Status ____________

☐Retired ☐ Disabled ☐Employed Occupation

Address ____________ City ____________ State ______ Zip ____________

Home phone ____________ Work phone ____________ Mobile phone ____________

Email Address

Who may we contact in case of an emergency? ____________ *Relationship* ____________

Address ____________ *City* ____________ *State* ______ *Zip* ____________

Home phone ____________ *Work phone* ____________ *Mobile phone* ____________

Email Address

Referring physician ____________ office phone ____________

Primary care physician ____________ office phone ____________

Other physicians you see regularly ____________

Primary health insurance ____________ ID# ____________ Group# ____________

Secondary health insurance ____________ ID# ____________ Group# ____________

Medical and Social History

What is the main reason for your visit today? ____________

Do you have any food or drug allergies ☐Yes ☐No Please list: ____________

Latex Allergy? ☐ Yes ☐No Iodine/X-ray dye allergy? ☐Yes ☐No

What medications/vitamins/herbal supplements are you taking? ____________

How often do you exercise? ☐ Regularly ☐ Occasionally ☐ Sedentary

☐ Unable Explain ____________

Have you ever used tobacco ☐Yes ☐ No Type ______ How much? ____________

How many years? ______ ☐Quit

Do you drink alcohol ☐Yes ☐No Type ________ How often? ______________________

How many years? ____

Do you use any street drugs ☐Yes ☐No Type ____________ How often? ___________

How many years? ____

Are you on dialysis? ☐Yes ☐No Type __________________ What days? __________

Date started? ____________ Access location ________________

Do you currently have or have you had any of the following within the past year:

☐Chest pain	☐Shortness of breath	☐Fatigue
☐Leg pain	☐Dizziness/fainting	☐Difficulty swallowing
☐Abdominal pain	☐Sudden vision changes	☐ Leg/arm swelling
☐Headache	☐Arm pain	☐ Back pain

Mark if you have ever had or currently have the following:

☐ High Blood Pressure	☐ Heart Valve Problems	☐ Non-healing Wound in Legs
☐ Heart Attack	☐ Coronary Artery Disease	☐ Gastric/Duodenal Ulcers
☐ Heart Failure	☐ Carotid Artery Disease	☐ Rectal Bleeding or Black Stool
☐ High Cholesterol	☐ Liver Disease	☐ Peripheral Vascular Disease
☐ Stroke or TIA	☐ Aortic Aneurysm or Dissection	☐ Excessive Bleeding or Bruising
☐ Blood Clots	☐ Asthma	☐ Rheumatic Fever
☐ Diabetes	☐ COPD	☐ Congenital Heart Disorder
☐ Kidney Disease	☐ Thyroid Disorder	☐ Irregular Heart Beat
☐ AIDS/HIV Positive	☐ Blood Transfusions	☐ Seizures or Epilepsy
☐ Cancer	☐ Genetic Disorder	☐ Pacemaker or Defibrillator

Do you have any other medical condition you are being treated or have been treated for not listed above? ☐Yes ☐No If yes please list: ______________________

What surgical procedure have you had? (list all procedures, and dates if possible)

Family History (please list cardiac/vascular history such as heart attack, heart valve disorder, bypass surgery, aneurysms, heart failure, stroke, diabetes, hypertension, stents in leg/heart, etc.)

Please list recent testing with dates: (CT scan, stress test, EKG, echocardiogram, heart cath, ultrasound, etc) ____

Have you ever had general anesthesia: ☐ Yes ☐ No

If yes, was there an adverse reaction? ______________________________