Cardiothoracic Surgery

Date: ______________________

Name: ______________________ Age:______ Marital Status:______________

Occupation:______________________ Family Physician:______________________

Referring Physician:______________ Height:__________ Weight:__________

Reason for office visit (or referral):

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Past Medical History: (list all major illnesses you have had in the past)

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Past Surgical History: (list all surgeries and the approximate date of surgery):

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Have you ever had a heart catheterization? Yes No

If yes, when was your last heart catheterization done?______________________

Name of hospital where procedure was done______________________

Name of physician who did this procedure______________________

Do you have varicose veins? Yes No

Have you ever had the veins in your legs stripped? Yes No

Do you have any of the following cardiac risk factors?

High blood pressure Yes No

Diabetes Yes No

High cholesterol Yes No

Heart disease Yes No

Do you drink alcohol? Yes No

Do you smoke? Yes No

How many packs day?________________

How long have you been smoking?________

If yes, how much do you drink a day?____

How active are you?____

Review of Systems: (Describe any problems you have with the following)

Ears, eyes, nose, throat & neck:____

Bones or joints:____

Lungs:____

Heart:____

Stomach or bowels:____

Muscles/Skin:____

Kidneys:____

Blood:____

Female/Male problems:____

Family history (list any major illnesses - heart disease, high blood pressure, diabetes, cancer, stroke, etc.)

Father:____

Mother:____

Brother(s):____

Sister(s):____

Children____

Grandparents____