

RED OAK CARDIOVASCULAR CENTER

17200 Red Oak Drive, Suite 107 • Houston, TX 77090
(281) 893-8640

MEDICAL HISTORY

Date: _____

Patient Name: _____

D.O.B.: _____ Sex: Male Female Height: _____ Weight: _____

Referring Physician: _____

Referred by (other sources): _____

Reason for seeing Dr. Amell/Dr. Rao/Dr. Grieco/Dr. Avendaño/Dr. Annamanini: _____

Do you have any Chest Pains/Chest Discomfort YES NO
(If YES, please describe in your own words) Severity Scale: (Least Severe) 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Do you have any of the following symptoms? YES NO

- Shortness of Breath
- Ankle Swelling/Fluid Retention
- Need to Urinate After Bedtime
- Sleep on More Than One Pillow
- Palpitations/Irregular Heart Beat
- Heartburn/Indigestion
- Excessive Perspiration
- Dizziness
- Headaches
- Vision Changes
- Coughing
- Fainting Spells
- Weakness or Numbness to Arms or Legs
- Aching in Legs When Walking
- Difficulty Sleeping
- Anxiety
- Depression

Do you have any history of the following conditions? YES NO

- Angina Pectoris (Chest Pain)
- High Blood Pressure
- Diabetes
- Arteriosclerosis (Hardening of the Arteries)
- Elevated Cholesterol
- Lung Disease (Emphysema)
- Anemia
- Arthritis
- Back Pain
- Gout

Have you ever had any of the following conditions? YES NO

- Heart Attack
- Abnormal EKG
- Chest Injury
- (Please Describe): _____
- Congestive Heart Failure
- Heart Murmur
- Rheumatic Fever
- Stroke
- Seizure Disorder
- Head Injury
- Pneumonia
- Abnormal Chest X-Ray
- Hiatal Hernia
- Ulcers
- Bleeding in Stomach
- Abdominal Aneurysm
- Gallbladder Stone(s)
- Diarrhea
- Constipation
- Kidney Stone
- Kidney Infection
- Blood Sugar Abnormality
- Thyroid Disorder
- Hepatitis
- Tuberculosis
- Cancer
- Breast Nodule
- Bleeding Tendency
- Easy Bruising
- Low Back Problems
- Bone Fractures

HOSPITAL ADMISSIONS INCLUDING SURGERIES:

Date:	Hospital:	Physician:	Diagnosis:	Surgeries:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PLEASE LIST ALL MEDICATIONS (Prescribed and Over the Counter Medicines):

Medicine	Dosage	Frequency Taken	Date Started	Date Stopped:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies: Medicine(s): _____
 Food: _____
 Environmental: _____
 Other: _____

PERSONAL HABITS:

Smoking: Did You Ever Smoke? YES NO How Many Packs per Day? _____
 How Many Years Did You Smoke? _____ Do You Smoke Now? YES NO
 When Did You Stop Smoking? _____

Alcohol Use: Current Amount of Wine, Liquor or Beer per Week? _____ Any History of Alcohol Use? YES NO

Drug Use: Any History of Illegal Drug Use/Abuse? YES NO
 If YES, Please Explain: _____

Exercise: Are You Currently on an Exercise Program? YES NO Number of Times per Week _____

Cholesterol: Have You Ever Had Your Cholesterol Checked? YES NO If So, When? _____
 What Were Your Levels? CHOL: _____ HDL: _____
 TRIG: _____ LDL: _____

Diet Restrictions: Salt Sugar Cholesterol/Low Fat Fluid Restrictions Caffeine
 Other: _____

Stress: Occupation: _____
 Marital Status: Married Single Widow Divorced
 Recent Major Life Changes: _____

Please Check the Following Tests Which have been Done Within the Past Year:

Female: Regular Physical Exams Pap Smear (Positive Negative) Breast Exam
 Mammogram Colon Exam

Male: Regular Physical Exams Prostate Exam Colon Exam

Do Members of Your Family Know CPR? YES NO Do You Know CPR? YES NO

FAMILY HISTORY:

Have You or Your Family Members Had Any of the Following Diseases (If YES, Please List Who They Are)?

Heart Disease: _____

Diabetes: _____

Hypertension: _____

Cancer: _____

Stroke: _____

Emphysema: _____