

DEPARTMENT OF CARDIOTHORACIC AND VASCULAR SURGERY

P) 713-486-5100 F) 713-512-7200

PATIENT MEDICAL HISTORY FORM

TODAY'S DATE: __/__/_____

Instructions: To provide you with the utmost quality of care, we request that you complete this form in its entirety. Please sign and date Page 5.

Patient Information

First Name		Last Name	
Address		City	
State		Zip Code	
Home phone #	()	Work phone #	()
Mobile phone #	()	E-mail address	
Date of Birth (dd / mm / yyyy)	___ / ___ / _____	___ Male ___ Female	Occupation
Social Security #	_____ / _____ / _____		
Name of spouse, parent or child		Relationship	
Address		City	
State		Zip Code	
Home phone #	()	Work phone #	()
Mobile phone #	()	E-mail address	
Referring physician		Office phone #	()
Primary care physician		Office phone #	()
Other physicians you see regularly			
Primary health insurance:	ID#:	Phone #: ()	
Secondary health insurance:	ID#	Phone #: ()	



Medical and Social History

Chief Complaint

What is the main reason for your visit today? (describe in detail)

Do you suffer from any of the following?

1. Heart and / or Blood Pressure Problems

If YES, please specify...

- High Blood Pressure
- Angina Pectoris
- Heart Attacks:
How many: _____ When? _____
- Heart Failure
- Previous Coronary Stenting / Ballooning
When? _____
- Previous Coronary Bypass Surgery:
When? _____
- Heart Valve Problems
- Previous Heart Valve Operations
When? _____
- Other Heart Problems?
Specify _____

2. Vascular Problems

If YES, please specify...

- Previous Stroke or TIA
- Previous Carotid Surgery (*neck*)
When? _____
- Pain in your legs
- Non-healing wounds in your legs
- Previous Vascular Surgery
When? _____
- Aortic Aneurysm
- Previous Aneurysm Surgery:
When? _____

3. Lung Condition

If YES, please specify...

- Asthma
- Emphysema
- Chronic Bronchitis / Pneumonia
- Lung Surgery or Intervention
- Other Lung Problems?
Specify _____



<p>4. Diabetes, Thyroid</p>	<p>If <input checked="" type="checkbox"/> YES, please specify... <input type="checkbox"/> Diabetes <input type="checkbox"/> Treated by Insulin, <input type="checkbox"/> Treated by pills, <input type="checkbox"/> Treated by diet <input type="checkbox"/> Do you suffer from any complications? Specify _____ <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other Endocrine conditions? Specify _____</p>
<p>5. High Cholesterol</p>	<p>If <input checked="" type="checkbox"/> YES, please specify... <input type="checkbox"/> Treated by Pills, <input type="checkbox"/> Treated by Diet <input type="checkbox"/> Is it a common problem in your family? Specify _____</p>
<p>6. Gastrointestinal</p>	<p>If <input checked="" type="checkbox"/> YES, please specify... <input type="checkbox"/> Liver Disease <input type="checkbox"/> Gastric / Duodenal Ulcers <input type="checkbox"/> Rectal Bleeding or Black Stools <input type="checkbox"/> Other Gastrointestinal Problems? Specify _____</p>
<p>7. Kidney</p>	<p>If <input checked="" type="checkbox"/> YES, please specify... <input type="checkbox"/> Renal (Kidney) Failure For how long? _____ <input type="checkbox"/> Do you require dialysis? For how long? _____ <input type="checkbox"/> Do you have a functioning dialysis access in your arm? <input type="checkbox"/> Do you have an intravenous catheter for dialysis? <input type="checkbox"/> What are the days you require dialysis? <input type="checkbox"/> Mon, <input type="checkbox"/> Tue, <input type="checkbox"/> Wed, <input type="checkbox"/> Thurs, <input type="checkbox"/> Fri, <input type="checkbox"/> Sat <input type="checkbox"/> Do you have a peritoneal catheter for dialysis?</p>
<p>8. Other</p>	<p>If <input checked="" type="checkbox"/> YES, please specify... <input type="checkbox"/> Have you been diagnosed with cancer? Specify _____</p>

<p>Do you use tobacco products</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>	<p>If <input checked="" type="checkbox"/> YES, please specify... Amount per day: <input type="checkbox"/> For how many years: <input type="checkbox"/></p>
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<p>Do you drink alcohol?</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>	<p>If <input checked="" type="checkbox"/> YES, please specify... Amount per day: <input type="checkbox"/> For how many years: <input type="checkbox"/></p>
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Past Surgical History

What surgical procedures have you had? (List <u>all</u> procedures, and if possible include the dates.)	
1.	
2.	
3.	
4.	
5.	
6.	

Prescribed Medications

What medications are you currently taking? (List <u>all</u> pills, patches, and any other forms of prescribed medications.)	
1.	Dose:
2.	Dose:
3.	Dose:
4.	Dose:
5.	Dose:
6.	Dose:

Allergies

What medications, food, or misc. substances are you allergic to? (Please describe type of reaction.)	
1.	Reaction:
2.	Reaction:
3.	Reaction:

General Anesthesia

Have you ever had procedures under general anesthesia?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If <input checked="" type="checkbox"/> YES, did you have any adverse reaction? Specify _____		



**DEPARTMENT OF CARDIOTHORACIC AND VASCULAR SURGERY
 6400 FANNIN STREET, SUITE 2850
 HOUSTON, TX 77030**

P) 713-486-5100 F) 713-512-7200

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I authorize _____ to release medical record information, which may include, but is not limited to, communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS); Psychiatry, as well as drug and/or alcohol abuse for the following patient:

Name of Patient: _____

Date of Birth: ___ / ___ / _____

Social Security Number: ___ ___ / ___ / _____

INFORMATION TO BE RELEASED:

- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> History & Physical Report | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Radiology (including reports and films) |
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Laboratory and other diagnostic test results |

INFORMATION TO BE RELEASED TO:

The University of Texas-Health Science Center at Houston
 Department of Cardiothoracic and Vascular Surgery
 6400 Fannin Street, Suite 2850
 Houston, TX 77030

Phone: 713-486-5100
 Fax: 713-512-7200

I understand that this authorization shall remain in effect for one year or until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written, dated request to revoke. Such revocation does not affect action that has already been taken based on this authorization.

Patient Signature: _____ **Date:** ___ / ___ / _____
Parent or Legal Guardian: _____ **Date:** ___ / ___ / _____
Witness Signature: _____ **Date:** ___ / ___ / _____