CARDIOVASCULAR HEALTH CLINIC
ADVANCED INTERVENTIONAL RADIOLOGY SOLUTIONS
3200 Quail Springs Parkway, Ste. 200
Oklahoma City, OK 73134
(O) 405-701-9880
(F) 405-701-9881
cvhealthclinic.com

New Patient History **Date:** _____

Name _____ DOB _____ Age _____

What doctor referred you to our clinic? Name _____ Phone Number _____

Who is your Primary Care Physician? _____

Reason for Visit: _____

Pharmacy name, Location, and Phone Number _____

Height _____ Weight _____

Allergies

Are you allergic to any medications: ☐ Yes ☐ No Are you allergic to Iodine? ☐ Yes ☐ No

If YES, please list medication and reaction _____

_____

Social History

Smoking Status

☐ Current Everyday ☐ Former Smoker ☐ Heavy Cigar/Pipe Smoker

☐ Current Some Day Smoker ☐ Never Smoker ☐ Light Cigar/Pipe Smoker

Type of Tobacco

☐ Cigarettes ☐ Chewing Tobacco ☐ Smokeless Tobacco/Other

☐ Cigars ☐ Vapor/E-Cigarettes ☐ Pipe

☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? ☐ 0-1 drinks/day ☐ 1-2 drinks/day ☐ over 3 drinks/day

Caffeine (coffee, tea, soda, energy drinks, etc.) ☐ None ☐ 0-1 drinks/day ☐ 1-2 drinks/day ☐ over 3 drinks/day

Do you use illicit drugs? ☐ Never ☐ Yes TYPE/FREQUENCY _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you employed? ☐ Yes ☐ No Is your work ☐ Sedentary ☐ Normal ☐ Labor Intensive

Are you retired? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If so what type and how often? _____

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Medications

List any medications you are currently taking, including over the counter medications.

Name	Dosage	Frequency

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Family History

		Mother	Father	Brother/ Sister	Brother/ Sister	Brother/ Sister	Son/ Daughter	Son/ Daughter	Son/ Daughter
Age									
If Deceased, Age at Death									
Cause of Death									
Check all that apply	Arrhythmia								
	Coronary Artery Disease								
	Heart Attack								
	Abdominal Aortic Aneurysm								
	Heart Failure								
	Hyperlipidemia								
	Hypertension								
	Sudden Cardiac Death								
	Stroke								
	Asthma								
	COPD								
	Diabetes								
	Cancer								

Medical History - have you ever had any of the following illnesses?

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Stroke	☐	☐
Chest Discomfort	☐	☐	Hepatitis	☐	☐
Heart Attack	☐	☐	Stomach Ulcers	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	Emphysema	☐	☐
Tuberculosis	☐	☐	Arthritis	☐	☐
Kidney Disease	☐	☐	AIDS	☐	☐
Thyroid Disease	☐	☐	Cancer	☐	☐
Elevated Cholesterol	☐	☐	Phlebitis	☐	☐
Carotid Disease/Blockage	☐	☐	Sleep Apnea	☐	☐
Peripheral Vascular Disease/Blockage	☐	☐	If you have sleep apnea, do you wear a CPAP?	☐	☐

Previous Cardiac Testing

	Yes	No	Date	Place
Ultrasound of Heart	☐	☐		
Stress Test	☐	☐		
Hearth CT Scan (Calcium Score)	☐	☐		
Ultrasound of Legs	☐	☐		

Surgical/Procedure History

	Yes	No	Date	Place
Arteriogram (Cath)	☐	☐		
Angioplasty (Balloon)	☐	☐		
Stent in the Heart	☐	☐		
Open Heart Bypass Surgery	☐	☐		
Heart Valve Replacement	☐	☐		
Pacemaker of Defibrillator	☐	☐		

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Other surgeries or procedures - please list surgery and approximate date:

_____

_____

_____

Peripheral Vascular Disease

Do you experience aching or cramping in your legs, thighs or buttocks when walking or exercising? ☐ Yes ☐ No

If yes, does the pain go away with rest? ☐ Yes ☐ No

Do you limit exercise due to leg cramps and/or pain? ☐ Yes ☐ No

Do you have numbness and tingling in your legs or feet? ☐ Yes ☐ No

Do you have open sores or ulcers on your leg(s) or feet that will not heal? ☐ Yes ☐ No

Do you suffer from varicose veins? ☐ None ☐ Some ☐ Moderate ☐ Severe

Do you suffer from spider veins? ☐ None ☐ Some ☐ Moderate ☐ Severe

Do you wear compression stockings? ☐ None ☐ Intermittent ☐ Daily

Review of Systems

Please check any of the symptoms you have experienced in the last 30 days. Any unchecked boxes will be assumed to be negative. Please check here if you are not experiencing any of the below symptoms ☐

Constitutional
- _____ Fatigue
- _____ Fever
- _____ Insomnia
- _____ Weight gain
- _____ Weight loss

Head/Neck
- _____ Headache
- _____ Neck pain

Eyes
- _____ Blurred vision
- _____ Decreased vision
- _____ Glaucoma
- _____ Cataracts

Ear, Nose, Mouth and Throat
- _____ Earache
- _____ Nasal Congestion
- _____ Sore throat
- _____ Ringing in ears

Cardiovascular
- _____ Chest pain
- _____ Pain in legs with walking
- _____ Decreased exercise tolerance
- _____ Palpitation
- _____ Awakened with breathing difficulty
- _____ Difficulty breathing lying flat
- _____ Swelling in your legs/feet

Pulmonary
- _____ Cough
- _____ Shortness of breath
- _____ Snoring
- _____ Sputum production
- _____ Wheezing

Gastrointestinal
- _____ Abdominal pain
- _____ Constipation
- _____ Diarrhea
- _____ Heartburn
- _____ Blood in stools
- _____ Loss of appetite
- _____ Nausea
- _____ Vomiting

Genitourinary
- _____ Pain on urination
- _____ Urinary frequency
- _____ Incontinence
- _____ Frequent urination at night
- _____ Urinary hesitancy

Musculoskeletal
- _____ Back pain
- _____ Foot pain
- _____ Joint pain/stiffness
- _____ Hip pain

Neurologic
- _____ Confusion
- _____ Lightheaded/Dizziness
- _____ Loss of balance/coordination
- _____ Slurred speech
- _____ Passing out
- _____ Weakness

Psychiatric
- _____ Anxiety
- _____ Depression

Patient Name:_____ DOB:_____