ALDERFER & TRAVIS CARDIOLOGY

HEALTH HISTORY QUESTIONNAIRE

PLEASE LIST ANY SIGNIFICANT FAMILY HISTORY OF HEART DISEASE:
(PARENT, SIBLINGS, AUNTS, AND UNCLES)

1. _____
2. _____
3. _____
4. _____
5. _____

PAST MEDICAL AND SURGICAL HISTORY

PLEASE LIST **ANY MEDICAL** PROBLEMS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE BEEN TREATED FOR IN THE PAST:

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE LIST ANY **SURGICAL** PROCEEDURES YOU HAVE UNDERGONE:

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE LIST ANY **CHILDHOOD** DISEASES (IE: RHEUMATIC HEART DISEASE, SCARLET FEVER):

- _____

DO YOU DRINK **ALCOHOL**?
(PLEASE CIRCLE ONE)

NEVER SOCIALLY QUIT

IF SO:_____DRINKS PER DAY
_____# OF YEARS

MEDICATIONS CURRENTLY TAKING:
(DRUG, DOSE, AND FREQUENCY)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

DO YOU **SMOKE**?

- NEVER SMOKED _____
- CURRENTLY SMOKING _____
  - PACKS/DAY _____
  - # OF YEARS _____
- QUIT SMOKING _____
  - YEAR QUIT _____
  - PACKS/DAY _____
  - # OF YEARS _____

ARE YOU ON A SPECIAL **DIET**? _____

IF SO, WHICH DIET?_____

PHYSICAL ACTIVITY

PLEASE LIST

_____

_____

DO YOU DRINK **CAFFEINE**? YES NO
IF SO: _____DRINKS PER DAY

GYN HISTORY

PRE MENOPAUSAL	YES	NO
MENOPAUSAL	YES	NO
POST MENOPAUSAL	YES	NO
ESTROGEN THERAPY	YES	NO

LIST **ALLERGIES** PLEASE:

1. _____
2. _____
3. _____
4. _____
5. _____

NAME: _____

DOB: _____

DATE: _____