

DIAGNOSTIC CARDIOLOGY OF HOUSTON, P.A.

NAME OF PATIENT: _____ DATE OF VISIT: _____

REFERRED BY DOCTOR: _____

Medication List: (please include strength & daily dose) _____

Reason for your visit: _____

Medical History:

1. Hypertension (high blood pressure) YES ___ NO ___

2. High cholesterol YES ___ NO ___

3. Smoking history (past or present, amount) YES ___ NO ___

4. Diabetes YES ___ NO ___

5. Previous surgeries: _____

6. Lifestyle: Do you exercise? YES ___ NO ___

What type of exercise? _____

7. Family History – (Father, Mother, Siblings, Aunts, Uncles, Maternal and paternal grandparents) history of heart disease, high blood pressure, diabetes? Please list:

8. Other medical problems: _____
