Grand Strand Heart & Vascular Care

Date: _____

Patient Name: _____ **DOB:** _____

Family Physician: _____

Smoking History: _____ **Alcohol History:** _____

Marital Status: (circle one) __Single __Married __Divorced __Partner __Widow/Widower __Separated

Drug Allergies: (LIST MEDICATIONS & THE SYMPTOMS CAUSED):

_____

PREFERRED PHARMACY: _____

CURRENT MEDICATIONS, VITAMINS & SUPPLEMENTS:

NAME OF MEDICATION	DOSAGE	TAKE	FREQUENCY
EX: Lisinopril	*20 mg*	*1 tablet*	*Once a day*

FAMILY HISTORY:	CARDIAC PROBLEMS Y/N	LIVING (AGE)	DECEASED (AGE)	CAUSE OF DEATH:
Mother				
Father				
Sisters				
Brothers				

Do you have any of the following:	*YES*	*NO*	*If so, WHEN?*
PAST MEDICAL HISTORY:			
Heart Catheterization			
Bypass surgery			
Valve surgery			
Pacemaker/ICD			
Stroke			
Kidney/Renal Failure			
Anemia/GI Bleed			
Allergy to contrast or dye			
Check any symptoms you have today			
Chest Pain			
Shortness of Breath			
Muscle Aches/ Joint Pain			
Fever			
Rash			
Vision Changes			
Cough			
Vomiting			
Incontinence			
Bleeding			
Seizure			
Anxiety/Depression			