CAPITOL VASCULAR CARE

Patient History

Last Name | First Name | Initial | Birthday

SS# | Primary Physician | Referring Physician | Cardiologist

Other Specialist

SOCIAL HISTORY: Select all that apply.

☐ Live with Family/Friends ☐ Live Alone Contact Name: Phone:

MEDICAL HISTORY: Please select any of the following conditions you have or had in the past, even if controlled with medication.

☐ Diabetes
☐ High Blood Pressure
☐ Heart Attack
☐ Heart Surgery
☐ Heart Stent
☐ Heart Failure
☐ COPD
☐ Stroke
☐ TIA ("ministroke")
☐ Kidney Disease
☐ Bleeding Problems
☐ Blood Clots
☐ Previous Vascular Surgery (list with dates):

Smoking: ☐ Current ☐ Quit (when?) ☐ Never

MEDICATIONS: Please select medications you take & list any others. Enter dose if known.

X	MEDICATION	DOSE, IF KNOWN
	Aspirin	
	Plavix (Clopidogrel)	
	CIlostazol (Pletal)	
	Pentoxyfilline (Trental)	
	Lipitor	
	Other cholesterol drug:	
	Beta Blocker (Toprol, Inderol, Metoprolol, Atenolol, Carvedilol)	
	Cardizem	
	Cozaar	
	Hyzaar	
	Clonidine	
	Diovan	
	Lisinopri	
	Losartan	
	Procardia	
	Other blood pressure medication:	
	Metformin	
	Insulin	
	Other diabetes medication:	
	Coumadin	
	Xarelto	
	Eliquis	

OTHER MEDICATIONS: Please list below (Including supplements, vitamins)

LIST ALLERGIES: ☐ None

Please list any known allergies below:

FAMILY HISTORY: Select all that apply.

☐ Heart Attack
☐ Heart failure
☐ Stroke
☐ Hypertension
☐ Aneurysm
☐ Diabetes
☐ PVD
☐ Bleeding
☐ Problems
☐ Blood Clots
☐ Varicose vein
☐ Other: