CARDIOLOGY SPECIALISTS
of Orange County

MEDICAL HISTORY
(Historial Médico)

Name (Nombre) _____ Date (Fecha)_____ AGE (Edad) _____

REASON FOR VISIT OR CHIEF COMPLAINT (Razón de la Visita o Queja Medica):

_____

_____

REFERRED BY (Dr. que la/lo Refirió): _____

PRESENT ILLNESS: (*to be filled out by physician*)

I. List any known allergies:

_____

_____

II. Have you ever had any of the following: (if yes, please check)

Scarlet Fever ☐	High Cholesterol ☐	Diptheria ☐
Heart Attack ☐	Rheumatic Fever ☐	Other Heart Disease ☐
Glaucoma ☐	Tuberculosis, Asthma or	Migraine Headaches ☐
Kidney or Bladder Problems ☐	Emphysema ☐	Stroke or Paralysis ☐
Chest Pain ☐	Cancer or Tumor ☐	Shortness of Breath ☐
High Blood Pressure ☐	Varicose Veins or Phlebitis ☐	Change in Weight ☐
Blood in Urine ☐	Chronic Cough ☐	Pneumonia or Pleurisy ☐
Heart Murmur ☐	Shortness of Breath when	Alcoholism ☐
Narcotic or Drug Habit ☐	Climbing a flight of stairs ☐	Swelling of Ankles ☐
Irregular, Palpitation, or Fast	Blood Disorder ☐	Pain or Cramps in Legs
Heartbeat ☐	Ulcer of Legs or Feet ☐	when Walking ☐

Have you had illnesses other than those listed above? ☐ Yes ☐ No .... (*If Yes, Please List*)

_____

Relation	Age if living	If dead – cause of death	Age of Death
Father			
Mother			
Brothers			
Sisters			
Wife or Husband			
Children			
Male			
Female			

VIII. List any significant family illnesses other than listed on previous page:

_____

_____

IX. OPERATION: Have you ever had surgical treatment or operations? (*if yes, list below)*

_____

_____

X. Have you ever had serious accidents or injuries? (*if yes, list below*) _____

_____

XI. Habits

Do you now or have you ever smoked? ☐ Yes ☐ No ☐ Cigars ☐ Cigarettes ☐ Pipe

If yes, how much _____ How long _____ (years) If you have stopped, how long ago_____ (years)

Do you follow a regular exercise program? _____

Do you drink alcoholic beverages? ☐ Never ☐ Occasionally ☐ Almost Daily ☐ More than above

Do you drink coffee? ☐ Yes ☐ No ☐ Less than 5 cups per day ☐ More than 5 cups per day

XII. Please List all current medications and dosage: _____

_____

_____

_____

Are you on any special diet? (Please Specify) _____