CARDIOLOGY SPECIALISTS
of Orange County

CSOC Doctor Name: _____ (Office use only)

MEDICAL HISTORY

(To be filled out by patient)

Patient Name: _____ Patient Date of Birth: _____

Today's Date: _____

Reason for visit or chief complaint: _____

Referred By _____

List of Current medication:

1. _____ Dose_____ Directions_____
2. _____ Dose_____ Directions_____
3. _____ Dose_____ Directions_____
4. _____ Dose_____ Directions_____
5. _____ Dose_____ Directions_____
6. _____ Dose_____ Directions_____

Allergies to Medications/ Latex (IF NONE, PLEASE WRITE NONE)

_____

_____

_____

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

1. **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 Heartbeat ☐	Blood Disorder ☐	Pain or Cramps in Legs
	Ulcer of Legs or Feet ☐	when Walking ☐

2). **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			
Children Male			
Female			

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

4.) **Have you had serious accidents or injuries?** ***(If yes, list below)***

5.) **Habits**

Do you now or have you ever smoked? Yes ___ No ___

If yes, how much_____ How long _____ *(years)* If you have stopped, how long ago

6.) Do you follow a regular exercise program? Yes ___ No ___ How Often:_____ Type of Exercise :_____

7.) Do you drink alcoholic beverages? Never ___ Occasionally ___ Almost daily ___

8.) Do you drink caffeine? Yes ___ No ___ Less than 5 cups per day ___ More than 5 cups per day ___

9.) Are you on any special diet? (Please specify) _____