Pinehurst Medical Clinic

Cardiovascular History and Risk Assessment

Name____ Referring MD__________________

Date_____________Age_________ Location______________________

Reason for Consult: Allergies__________Can you eat shrimp_____

Current Medication/Dosages: ____

____

____

Past Medical/Surgical Problems

Thyroid_____Liver_______GI_______Kidney______Cancer______Bleeding_______Gout__________
Migraine HA_____Surgeries____
Other:____

Cardiovascular Risk Factors: (if yes, date and facility)

Heart____
Cardiac Catheterization_________________________Angioplasty/Stent_________________________
Heart Attacks____
Coronary Artery Bypass Graft____
Stroke____Leg Pain _______________________________
Congestive Heart Failure___________________________________Edema/Location_______________
Atrial Fibrillation/Palpitations____
Cholesterol hx____
High Blood Pressure______________________________Lung Problems _______________________
Diabetes/Sugar____
Smoking (if yes, length of time, quantity, attempts and methods of cessation) ____________________

____

Exercise____
Weight gain or loss____Waist size (inches)___________
Hormone Replacement Therapy____
Cancer____

Family Hx:	**Diagnosis**	**Family Member**	**Living? (if no, age at death)**
	Coronary Artery Disease		
	High Blood Pressure		
	Diabetes/Sugar		
	Cancer		
	Other		

Social Hx: (Smoking addressed in CV risk factors above)

Alcohol____________________Herbal Medicines ____
Home Remedies_____________________________________
Type of Employment (i.e. activity level of employment) ____________________________________

Physical Activity (i.e. type, amount, frequency, intensity, limitations)

____

Stress (identify sources)

____