Winchester Cardiology and Vascular Medicine P.C.

Patient's Personal History

Confidential Record: Information contained here will not be released except when you authorize us to do so.

Last Name:	First Name:	Middle:		Birth Date:	Age:
Address:	City:	State:	Zip:	Sex:	Marital Status:
Email Address:	Cell Phone:			Home Phone:	
Social Security Number:	Employer Name:			Business Phone:	
Insurance Company:	Policy Number:			Insurance Phone Number:	
Emergency Contact:		Relationship:			
Address:		Phone Number:			

Reason for Today's Visit:

_____

_____

Past Medical History		
High Blood Pressure:	□ No	□ Yes
Diabetes:	□ No	□ Yes
High Cholesterol:	□ No	□ Yes
Other:		
Other:		
Other:		

Past Surgical History		
Coronary Bypass:	□ No	□ Yes
Heart Valve Surgery:	□ No	□ Yes
Pacemaker/Defibrillator:	□ No	□ Yes
Stents/Angioplasty:	□ No	□ Yes
Other:		
Other:		

Family History

			Medical Problems (check or describe if yes)							**If Deceased**	
	Age	**M/F**	Stroke	Cancer	High Blood Pressure	Diabetes	Heart Disease	High Cholesterol	Other	**Age at Death**	**Cause**
Father			□	□	□	□	□	□			
Mother			□	□	□	□	□	□			
Siblings											
			□	□	□	□	□	□			
			□	□	□	□	□	□			
			□	□	□	□	□	□			
			□	□	□	□	□	□			
Children											
			□	□	□	□	□	□			
			□	□	□	□	□	□			
			□	□	□	□	□	□			
			□	□	□	□	□	□			

SEE OTHER SIDE

Please indicate **NEW** or **CHANGED** symptoms since last visit:

GENERAL	**CARDIOVASCULAR**	**RESPIRATORY**
□ Fatigue	□ Chest pain or discomfort	□ Shortness of breath
□ Unintentional weight change	□ Difficulty breathing lying down	□ Sleep on more than one pillow
□ Unexplained hair loss	□ Swelling in ankles or feet	□ Sudden awakening from sleep w/ shortness of breath
□ Trouble sleeping	□ Palpitations	
GASTROINTESTINAL	**MUSCULOSKELETAL**	**NEUROLOGICAL**
□ Heart burn	□ Difficulty walking	□ Dizziness
□ Acid reflux	□ Pain or heaviness in legs	□ Fainting
□ Rectal bleeding		□ Headache
ENDOCRINE	**GENITOURINARY**	**HEMATOLOGIC/LYMPHATIC**
□ Heat or cold intolerance	□ Kidney problems	□ Unexplained bruising
□ Thirst	□ Blood in urine	□ Bleeding disorder
□ Change in appetite		
SKIN (INTEGUMENTARY)	**ALLERGIC/IMMUNOLOGIC**	**EAR/NOSE/THROAT**
□ Rash related to medications	□ New reaction to medication	□ Hoarseness
□ Ulcers on legs, feet		□ Difficulty swallowing
EYES	**PSYCHIATRIC**	
□ Unexplained vision changes	□ Excessive stress	
Are you planning surgery within the next six months? □ No □ Yes If yes, what type? _____		
Do you have varicose veins? □ No □ Yes		