MISHKEL HEART & VASCULAR CENTER

1599 NW 9TH AVE #203, BOCA RATON, FL 33486

MEDICAL HISTORY

In order to assist us in accurate history of your condition, please answer the following questions.

Name:_____ Age:_____

Your chief complaint:_____

Your current medications:_____
_____
_____
_____

Medication allergies:_____
_____

Do you or have you had any of the following?

□ High blood pressure
□ High cholesterol
□ Diabetes
□ Emphysema
□ Coronary bypass grafting surgery
□ Coronary angioplasty or stent placement
□ Pacemaker
□ Atrial fibrillation
□ Artificial valve
□ Defibrillator
□ Rheumatic fever as a child
□ A stroke or mini stroke
□ Chest pressure or tightness (angina)
□ Shortness of breath on exertion
□ Fainting
□ Palpitations
□ Swollen ankles
□ An echocardiogram
□ A stress test
□ A heart catheterization (angiogram)
□ Cough
□ Asthma
□ Tuberculosis (TB)

□ Blood clots in the legs or lungs
□ Blood in the toilet / black tarry stools
□ Change in bowel habits
□ Weight loss
□ Peptic ulcers
□ Liver disease
□ Leg cramps with exercise
□ Arthritis
□ Gout
□ Thyroid disease
□ Depression
□ Anemia
□ Erectile dysfunction
□ Radiation treatment
□ Fevers

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In order to assist us in accurate history of your condition, please answer the following questions.

Name:_____ Age:_____

Do you smoke? _____ If so, how many packs per day? _____
If you quit smoking, when? _____

How many alcoholic beverages do you consume per day? _____
How many caffeinated beverages do you consume per day? _____
What type of exercise do you do? _____

Are you:
□ Single
□ Married
□ Employed (What is your occupation?) _____
□ Retired (What was your occupation?)_____
□ A permanent resident
□ A seasonal resident

Do you:
□ Have a primary physician or cardiologist outside of Florida

Name:_____

Address:_____
_____
_____

Phone number:_____

□ Has anyone in your family had a heart attack before the age of 70?
If so, at what age:_____
How are they related to you?_____

□ List all of your surgeries & dates:
_____
_____
_____