TEXAS VEIN HEALTH
VIJAY S. RAMANATH, MD

HeartPlace®

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ Date: _____

CURRENT MEDICATIONS / SUPPLEMENTS ☐ Yes ☐ No

Please list ALL the medications that you are taking at home. Include ALL prescription medications, non-prescription medications, vitamins, herbal remedies and supplements.

Name of Medication	Dose/Strength	How Many/How Often/When *Example*
Lasix	*40 mg*	*twice a day - morning and night*

(Please attach additional pages if necessary)

ALLERGIES / INTOLERANCES TO MEDICATIONS ☐ Yes ☐ No

Please list any medications, or materials you are allergic to, had an adverse reaction to, or do not tolerate and describe the reaction.

Medication	Reaction (e.g. hives, swelling, short of breath, rash, etc)

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BRIEF PATIENT HISTORY

Patient Name: _____ **DOB:** _____

REASON FOR VISIT: _____ **PCP:** _____

PAST MEDICAL HISTORY: (Check all that apply. List approximate date of initial diagnosis or event)

Gallbladder Problem	_____ Date _____	Chest Pain	_____ Date _____
Stomach Problem	_____ Date _____	Shortness of Breath	_____ Date _____
Lung Problem	_____ Date _____	Irregular Heartbeat	_____ Date _____
Thyroid Problem	_____ Date _____	Dizziness	_____ Date _____
Artery Blockage	_____ Date _____	Leg/ankle Swelling	_____ Date _____
Blood Clot	_____ Date _____	Nausea	_____ Date _____
Stroke	_____ Date _____	Unusual Sweating	_____ Date _____
Heart Attack	_____ Date _____	Leg Pain with Walking	_____ Date _____
Arrhythmia	_____ Date _____	Sores or Ulcers on Legs	_____ Date _____

Prior Stress Test: Y or N Approximate Date: _____ Location: _____

List Cardiac or Vascular Procedures/Operations (eg. Heart cath, angioplasty/stent, bypass or valve surgery, pacemaker, defibrillator) and approximate dates:

_____

_____

RISK FACTORS:

Cholesterol Level (if known) – Total: _____ LDL (bad): _____ HDL (good): _____ TG: _____ Date: _____

Tobacco Use? *(Circle One)* Current → _____ Packs/day for _____ years

TYPE: _____ Former → _____ Packs/day for _____ years. Quit Date: _____

High Blood Pressure? Y or N Date: _____ Home Monitor? Y or N

Diabetes? Y or N Date: _____ Treated with: _____ diet _____ pills _____ insulin

FAMILY HISTORY OF HEART DISEASE:

Relative	Type of Heart Disease	Age of Onset	Heart was cause of death (age)
Mother			
Father			

SOCIAL HISTORY:

____ Single ____ Widowed ____ Married ____ Divorced Occupation: _____

Diet? ____ Regular ____ Low Fat ____ Low Salt/Sodium ____Weight Loss ____ Diabetic Other: _____

Exercise? Y or N if yes: _____ times/week for _____ minutes

Alcohol Use? Y or N if yes: _____ Social _____Moderate _____ Heavy Types: _____

Caffeine Intake? Y or N if yes: _____ cups/day Types: _____