Peak
Heart & Vascular

PATIENT HEALTH HISTORY

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Email: _____

Primary Care Physician Name: _____ Referring Physician Name: _____

Preferred Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City: _____ ST: _____ ZIP: _____

Are you currently taking Coumadin (Warfarin / Blood Thinner)? [ ] Yes [ ] No

Do you have a pacemaker? [ ] Yes [ ] No

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

(Include Prescription, Over the Counter, Herbal Medications and Supplements)

MEDICATION:	DOSE:	TIMES PER DAY:

main 602-698-PEAK (7325) | fax 480-500-8430
info@peakheart.com | peakheart.com

Peak
Heart & Vascular

WHAT MEDICATIONS DO YOU HAVE AN ALLERGIC REACTION TO?

MEDICATION:	REACTION:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HISTORY?

Check the box if you have a ***family history*** of any of the following:

CONDITION:	PARENT:	SIBLING:
Heart Attack	[ ]	[ ]
Stroke	[ ]	[ ]
Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
High Cholesterol	[ ]	[ ]
PVD, Abdominal Aortic Aneurysm	[ ]	[ ]
Sudden Cardiac Death	[ ]	[ ]

Check the box if you have a ***personal history*** of any of the following:

CONDITION:	DATE?	HOW IS IT TREATED?
[ ] Heart Surgery/Procedures	_____	_____
[ ] Aneurysm Surgery	_____	_____
[ ] Carotid Surgery	_____	_____
[ ] Vascular Surgery/Procedures	_____	_____
[ ] Diabetes	_____	_____
[ ] High Blood Pressure	_____	_____
[ ] High Cholesterol	_____	_____
[ ] Stroke	_____	_____
[ ] Palpitations	_____	_____
[ ] Chest Pain	_____	_____
[ ] COPD	_____	_____
[ ] Congestive Heart Failure	_____	_____
[ ] Asthma	_____	_____

Peak
Heart & Vascular

Check any major hospitalizations:

CONDITION:	DATE	NAME OF HOSPITAL
[ ] Chest Pain		
[ ] Cardiac Complaint		
[ ] Heart Attack		
[ ] Shortness of Breath		
[ ] Stroke		
[ ] Fainting		
[ ] Congestive Heart Failure		
[ ] Arrhythmia		
[ ] High Blood Pressure		
[ ] Peripheral Vascular Complaint		
[ ] COPD		
[ ] Congestive Heart Failure		
[ ] Asthma		

How many alcoholic beverages do you consume each day? _____
How many caffeinated beverages do you consume each day? _____
How many cigarettes do you smoke each day? _____
How often do you exercise? _____
Do you have a history of or currently use recreational drugs? [ ]Yes [ ]No If yes, how often?_____
Do you have advanced directives? [ ]Yes [ ]No If yes, please provide us with a copy for your chart.

Are there any other medical concerns we should be aware of?

_____
_____
_____
_____
_____