Cardiac & Vascular
INTERVENTIONAL GROUP
The CVI Group

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HISTORY

Name: ______________________________ Date: ______________
Age: _____Years, Date Of Birth: ______/______/______ Sex: ☐Male ☐Female Height:__________ Wt:__________
Mobile Phone Number: ______________________________
Home Phone Number: ______________________________
Email:______________________________
Primary Care Provider: ______________________ Phone Number: ______________
Address:______________________ City/State/Zip: ______________
Preferred Pharmacy Name:______________________ Phone Number: ______________
Where you referred by a physician? (Please circle)Yes Or No. If not, what is the reason for your visit?
____
Physicians Name:______________________ Phone Number:______________

PAST MEDICAL HISTORY

CHECK ALL THAT APPLY: ☐NONE APPLY

- ☐Heart Attack
- ☐Heart Failure (CHF)
- ☐High Blood Pressure
- ☐Rheumatoid Arthritis
- ☐Ankylosing Spondylitis
- ☐Blood Clot In Lung
- ☐Blood Clot In Leg
- ☐Serious Injury(Explain)______________________
- ☐Other______________________
- ☐Diabetes
- ☐Stroke
- ☐Seizures
- ☐Osteoarthritis
- ☐Mental Illness
- ☐Kidney Stones
- ☐Kidney Failure
- ☐HIV
- ☐AIDS
- ☐Tuberculosis
- ☐Alcoholism
- ☐Asthma
- ☐Stomach Ulcers
- ☐Osteoporosis
- ☐Liver Disease
- ☐Hepatitis
- ☐Thyroid Trouble
- ☐Bleeding Disorders
- ☐Anemia
- ☐Gout
- ☐Lung Disease
- ☐Cancer

TESTS DONE TO EVALUATE YOUR HEART CONDITION

Name of Study	Where	Date of Study

PAST SURGICAL HISTORY

LIST PROCEDURES, SURGEON AND DATE ☐NONE APPLY

Operation	Surgeon	Date of Surgery

REVIEW OF SYSTEMS

ARE YOU CURRENTLY OR HAVE HAD PROBLEMS WITH:
**PLEASE EXPLAIN AND DESCRIBE ALL YES ANSWERS BELOW*

Hematological/Bleeding Problems: □Yes □No Describe: ____________________
Reproductive/Sexual Problems: □Yes □No Describe: ____________________
Unexplained Weight Loss: □Yes □No Describe: ____________________
Skin: □Yes □No Describe: ____________________
Ear, Nose, Throat: □Yes □No Describe: ____________________
Stomach/Digestion: □Yes □No Describe: ____________________
Bladder/ Bowel Problems: □Yes □No Describe: ____________________

Musculoskeletal: □Yes □No Describe: ____________________
Neurological: □Yes □No Describe: ____________________
Psychiatric Problems: □Yes □No Describe: ____________________
Fever/Chills: □Yes □No Describe: ____________________
Night Sweats: □Yes □No Describe: ____________________
Night Pain/Pain at Rest: □Yes □No Describe: ____________________

SOCIAL HISTORY

Work Status: □Home Maker □Retired □Disabled □On-Leave □Unemployed
□Employed: □Full Time □Part-Time
Occupation: ____________________
Marital Status: □Married □Single □Divorced □Widowed
Number Of Living Children: ________ □None
I Live: □Alone With: ____________________

Do You Smoke? □Yes □No ______pack per day for __________years
□Quit □How long ago? ____________________
Drink Alcohol? □Daily □½ Week □1-2 Month □Never
□Alcoholic □Recovering Alcoholic
Illicit Drug Use: □Never □Currently □In the past

FAMILY HISTORY

CHECK ALL THAT APPLY: □ None Apply

□Stroke □Arthritis □Mental Illness □Alcoholism
□Heart Trouble □Gout □Kidney Trouble/Stones □Cancer
□High Blood Pressure □Seizures □Diabetes □Spine Problems
□Bleeding Disorders
Other: ____________________

ALLERGIES: ____________________

MEDICATIONS

LIST ALL CURRENT MEDICATIONS AND DOSE □ None
Medication ____________________ Dose ____________________

____

____

____

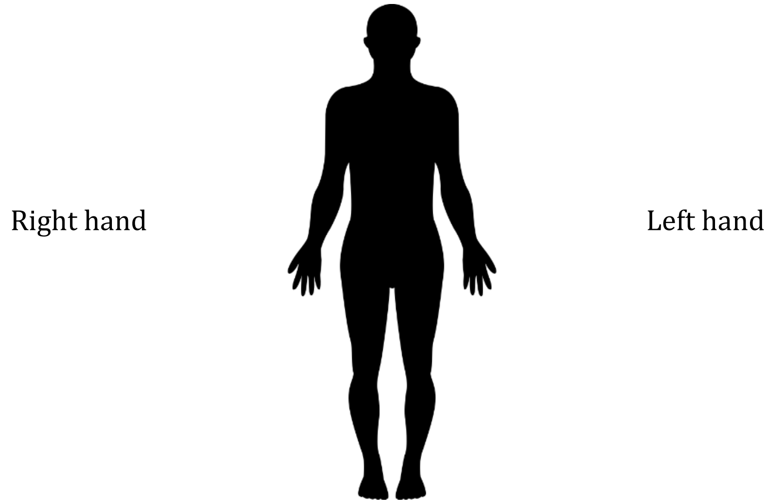
PERIPHERAL VASCULAR QUESTIONNAIRE

Name: ____________________ Date: ____________

Peripheral vascular disease is a common circulation problem in which the blood vessels, which carry blood to the legs and/or arms, become narrowed or clogged. Please fill out the questionnaire to help us identify if you have symptoms of peripheral vascular disease. Check yes or no to the following questions:

1. Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks when you walk or exercise? ☐ Yes ☐ No

   If you answered "yes" to question number 1, circle the area of the body on the diagram below where you feel pain:



2. If you answered "yes" to the question number 1, Does the pain go away with rest? ☐ Yes ☐ No
3. Do you have numbness and tingling in the arms or lower legs and feet? ☐ Yes ☐ No
4. Are your fingers or toes pale, discolored or bluish? ☐ Yes ☐ No
5. Are your hands or feet cold to the touch? ☐ Yes ☐ No
6. Do you have open sores or ulcers on your legs or feet that will not heal? ☐ Yes ☐ No
7. Do you exercise on a regular basis? ☐ Yes ☐ No
   If not, what keeps you from exercising? ____________________
8. Do you have family history of diabetes or cardiovascular problems (immediate family: parent, sister, brother)? ☐ Yes ☐ No
9. Have you had any previous surgeries and/or angioplasty on the arteries in your legs, arms, kidneys or brain? ☐ Yes ☐ No
   If yes, describe the procedure; where and when it was performed:
   ____
   ____