THE TEXAS HEART INSTITUTE®
CENTER FOR CARDIOVASCULAR CARE
6624 Fannin, Suite 2600 • Houston, Texas 77030 • (713) 790-9401

# MEDICAL HISTORY / MEDICATION SHEET

Patient Name: _____ DOB: _____ Date of Visit: _____

## Pharmacy Information:

Check which pharmacy refills should be sent to:
Local Pharmacy Name: _____ Phone #: _____
Mail Order Pharmacy Name: _____
Primary Care Physician Name & Phone #: _____

Please list all medications, vitamins, herbal supplements and any other over-the-counter medication you are taking with the strength and directions of each. (PLEASE LIST EVERY PILL YOU TAKE)

| MEDICATIONS / VITAMINS | STRENGTH (Ex. 50 mg) | DIRECTIONS (Times a day) | MEDICATIONS / VITAMINS | STRENGTH (Ex. 50 mg) | DIRECTIONS (Times a day) |
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Allergies: _____

## Past Medical History:

Please summarize your medical history. Indicate if you have had diabetes, hypertension, high cholesterol, cancer, thyroid, pulmonary, neurologic disease, kidney disease, gastroenterologic disease, etc. Note the approximate onset in months/years.

_____
_____
_____

## Family History:

Please summarize illnesses that your family members (parents, brothers/sisters, etc.) have or have had. Include age at time of onset of illness and age at time of death (ex. Heart attack at 56 and died of heart failure at 60. He also had diabetes and high blood pressure. He was a heavy smoker)

Mother: _____
Father: _____
Brothers/Sisters: _____
Other: _____
_____

## Social History:

Do you or have you ever smoked or used any other tobacco products? ☐ Yes: ☐ No How much per day/week? _____
Do you consume alcohol? ☐ Yes: ☐ No How much per day/week? _____
Past Surgical History: Please indicate type of surgery, date and why it was done (ex. Hysterectomy at 45 for fibroids)

_____
_____

How did you hear about our practice? _____
Primary Care Physician (address and phone number): _____