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: ____________

Primary Care Physician (name, address and phone number): ____________________

How did you hear about our practice? ____________________

Pharmacy Information:

Check which pharmacy refills should be sent to:
Pharmacy Name: ____________________ Phone #: ____________
Pharmacy Address: ____________________
Mail Order Pharmacy Name: ____________________

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)
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

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.

Past Surgical History: Please indicate type of surgery, date and why it was done (ex. Hysterectomy at 45 for fibroids)

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? ____________