Main Line HealthCare
Physician Network

Lankenau Heart Group

Patient Name:_____ **DOB:**_____

CARDIOLOGY MEDICAL HISTORY

Chief Complaint: (reason why you are here)_____
_____

Medical History: (include date, if known)

- ☐ Heart Attack_____
- ☐ Chest Pain_____
- ☐ Coronary Artery Disease_____
- ☐ Heart Failure_____
- ☐ High blood pressure_____
- ☐ Peripheral vascular surgery_____
- ☐ High cholesterol_____
- ☐ Stroke or TIA_____
- ☐ Heart Murmur_____
- ☐ Abnormal heart rhythm or heart beat_____
- ☐ Asthma_____
- ☐ COPD/Emphysema_____
- ☐ Bleeding disorders_____
- ☐ Abnormal clotting_____
- ☐ Ulcers_____
- ☐ Deep vein thrombosis_____
- ☐ Peripheral vascular disease_____
- ☐ Kidney disease_____
- ☐ Cancer, what type_____
- ☐ Hepatitis_____
- ☐ Thyroid Disease_____
- ☐ Coronary bypass surgery_____
- ☐ Diabetes_____
- ☐ Cardiac Cath_____
  - ☐ with stent_____
- ☐ Pacemaker_____
- ☐ ICD (defibrillator)_____
- ☐ Treadmill stress test_____
- ☐ Nuclear stress test_____
- ☐ Echocardiogram_____
- ☐ Stress Echocardiogram_____
- ☐ List all other surgeries or procedures:

_____
_____
_____
_____
_____

CURRENT MEDICATIONS including the name, dose, how often you take each one. (Continue on back if needed)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements, over-the-counter vitamins, etc.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had an allergic reaction to or side effects from medication? ☐ Yes ☐ No
If Yes, please list the medication and the reaction you had_____

Have you ever had an allergic reaction to intravenous dye, iodine, shellfish or food: ☐ Yes ☐ No
If Yes, please explain:_____