CARDIOVASCULAR SOLUTIONS

PATIENT GENERAL INFORMATION

Name: _____

Age: ____ Date of Birth: _____

Address: _____

Neighborhood (Colonia): _____ City: _____

Phone Number: _____ Email: _____

Referring Doctor´s name (if applicable): _____

FAMILY HISTORY:

High Blood Pressure	☐	Diabetes Mellitus	☐
Heart Attack	☐	Stroke	☐
High Cholesterol / Triglycerides	☐	Cancer	☐
Thyroid Disease	☐	Alzheimer	☐

Other: _____

PERSONAL HISTORY:

Blood Type: _____

Allergies: _____

Smoker? ☐ Starting age: _____ Cigarettes/day: _____

Do you exercise regularly?: Yes ☐ No ☐

High Blood Pressure: Yes ☐ No ☐ Year of diagnosis: _____

Diabetes: Yes ☐ No ☐ Year of diagnosis: _____

High Cholesterol / Triglycerides? Yes ☐ No ☐ Year of diagnosis _____

Heart Attack? Yes ☐ No ☐ Year of event _____

Previous stroke? Yes ☐ No ☐ Year of event _____

Prior Surgeries: _____

_____

_____

Current Medications (please indicate the dose / times a day)

_____

_____

_____

_____

Please explain briefly the reason of your consultation:

_____

_____

_____

_____

_____

_____

_____

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