Texas Interventional Radiology

PRE - VISIT FORM

Please print out this form and bring it with you when you visit our office.

PATIENT INFORMATION:

Patient Name: _____ Date: _____

Phone (Check Preferred): Cell _____ Home _____

Other _____

Referring Physician: _____

Family Physician: _____

Date of Birth: _____ Age: _____ Weight: _____ lbs Height: _____ ft _____ in

Gender: ◯ female ◯ male

Marital Status: ◯ single ◯ married ◯ widowed ◯ divorced

Number of Children: _____

PERSONAL HEALTH HISTORY:

What is the reason for this visit?

Have you ever had a heart problem?

◯ Yes ◯ No

If yes, please explain:

Do you have or have you ever had any of the following?

- ☐ Rheumatic fever Date: _____
- ☐ Heart murmur Date: _____
- ☐ Heart attack Date: _____
- ☐ Chest pain/pressure Date: _____
- ☐ Heart failure Date: _____
- ☐ Rapid heart beat or irregular pulse Date: _____
- ☐ Light headedness Date: _____
- ☐ Dizziness Date: _____
- ☐ Fainting Date: _____
- ☐ Swelling of the ankles Date: _____
- ☐ Pain in calf muscles when walking Date: _____
- ☐ Congestive heart failure Date: _____
- ☐ Shortness of breath Date: _____

Do you have or have you ever had any of the following?

- ☐ EKG
- ☐ Echocardiogram
- ☐ 24 Hour Monitor
- ☐ Cardiac Catheterization
- ☐ Treadmill
- ☐ Chest X-Ray

Other: _____

Have you ever had a reaction to the dye used in certain cardiac x-rays?

◯ Yes ◯ No I have never had this type of x-ray

Do you have allergies to medication?

◯ Yes ◯ No

If yes, which medications?

Do you currently smoke?	◯ Yes	◯ No	Packs per day: _____
			Number of Years: _____
Have you ever smoked?	◯ Yes	◯ No	Date stopped: _____
Do you have elevated cholesterol?	◯ Yes	◯ No	Last checked: _____
Do you have high blood pressure?	◯ Yes	◯ No	How many years: _____
Do you drink alcoholic beverages?	◯ Yes	◯ No	How much each day: _____
Are you generally stressed?	◯ Yes	◯ No	
Do you drink beverages containing caffeine?	◯ Yes	◯ No	How much: _____
Do you exercise?	◯ Yes	◯ No	

If yes, what is your exercise routine?

Are you following a special diet?	◯ Yes	◯ No	Type: _____

Occupation: _____

Are you retired?	◯ Yes	◯ No
Are you disabled?	◯ Yes	◯ No

If yes, describe your disability:

Describe any surgeries you have had:

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Please check any other health condition you have or have had in the past:

- ☐ Scarlet fever
- ☐ Anxiety
- ☐ Emphysema
- ☐ Ulcer
- ☐ Anemia
- ☐ Arthritis
- ☐ Stomach or bowel disorder
- ☐ Fatigue
- ☐ Menstrual dysfunction
- ☐ Kidney disease
- ☐ Breathing problems
- ☐ Venereal disease
- ☐ Sexual dysfunction
- ☐ Asthma
- ☐ Allergies/ Hay fever
- ☐ Gout
- ☐ Cancer _____
- ☐ Urinary problem
- ☐ Rheumatic fever
- ☐ Depression
- ☐ Constipation
- ☐ Thyroid disease
- ☐ Diabetes / high blood sugar
- ☐ Migraine headache
- ☐ Liver disease
- ☐ Other _____

FAMILY HISTORY:

Do you have a history of heart disease in your family? ◯ Yes ◯ No
If yes, indicate relation and age problems started:

Family Member(s)	Alive	Deceased	Age or Age at death	Cause of death
Mother	◯	◯	_____	_____
Father	◯	◯	_____	_____
Sister(s)	◯	◯	_____	_____
	◯	◯	_____	_____
	◯	◯	_____	_____
Brother(s)	◯	◯	_____	_____
	◯	◯	_____	_____
	◯	◯	_____	_____

This form is not electronically submitted.
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