

Medical History (to be filled out by patient) Name _____ date _____

**LOS ANGELES CARDIOTHORACIC
& VASCULAR SURGERY**

Medications	Dose	Frequency	Medications	Dose	Frequency

Allergies: (Type of Reaction) _____

Social History:

Habits: Tobacco Y / N pack(s)/day _____ duration _____ quit _____
Alcohol Y / N quantity _____ frequency _____ quit _____
Recreational
Drugs Y / N quantity _____ frequency _____ quit _____
Marital Status: Married Y / N duration _____ widowed _____ divorced _____
Children Y / N sons _____ daughters _____

Occupation: _____ retired Y / N

Residence: City born _____
Other cities _____
Current city _____
Currently lives with _____
Stairs at home Y/N _____

Activity: Exercise Y / N Type _____
Walking distance _____

Hobbies: _____

Family History:	Major Medical Illness	Deceased	Age	Cause
Father		Y / N		
Mother		Y / N		
Siblings		Y / N		