

Texas Cardiology Associates of Houston

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Cardiology
Interventional Cardiology
Board Certified

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Patient Name: _____ Date of Birth: _____

Family History

- Does your Father have history of: High Blood Pressure Diabetes CAD High Cholesterol
 Heart Problems Past Heart Attack Arrhythmias Lung Problems Cancer
- Does your Mother have history of: High Blood Pressure Diabetes CAD High Cholesterol
 Heart Problems Past Heart Attack Arrhythmias Lung Problems Cancer
- Does your Siblings have history of: High Blood Pressure Diabetes CAD High Cholesterol
 Heart Problems Past Heart Attack Arrhythmias Lung Problems Cancer
- Does your Fathers Parents have history of: High Blood Pressure Diabetes CAD High Cholesterol
 Heart Problems Past Heart Attack Arrhythmias Lung Problems Cancer
- Does your Mothers Parents have history of: High Blood Pressure Diabetes CAD High Cholesterol
 Heart Problems Past Heart Attack Arrhythmias Lung Problems Cancer
- Does your Uncles have history of: High Blood Pressure Diabetes CAD High Cholesterol
 Heart Problems Past Heart Attack Arrhythmias Lung Problems Cancer
- Does your Aunts have history of: High Blood Pressure Diabetes CAD High Cholesterol
 Heart Problems Past Heart Attack Arrhythmias Lung Problems Cancer

Past Medical History

- | | | | | | |
|-----------------------------|---------------------------|----------------------------|---------------------------|--------------------------|---------------------------|
| Anemia | <input type="radio"/> Yes | Aortic regurgitation | <input type="radio"/> Yes | Aortic stenosis | <input type="radio"/> Yes |
| Arthritis | <input type="radio"/> Yes | Asthma | <input type="radio"/> Yes | CAD post stent | <input type="radio"/> Yes |
| Peripheral vascular disease | <input type="radio"/> Yes | Atrial fibrillation | <input type="radio"/> Yes | Atrial flutter | <input type="radio"/> Yes |
| Bowel disorders | <input type="radio"/> Yes | Bronchitis, chronic | <input type="radio"/> Yes | Cardiac arrhythmia | <input type="radio"/> Yes |
| Cardiac murmur | <input type="radio"/> Yes | Cardiomyopathy | <input type="radio"/> Yes | Carotid stenosis | <input type="radio"/> Yes |
| Cataracts | <input type="radio"/> Yes | Cirrhosis | <input type="radio"/> Yes | Congestive heart failure | <input type="radio"/> Yes |
| Coronary artery disease | <input type="radio"/> Yes | COPD | <input type="radio"/> Yes | Deep vein thrombosis | <input type="radio"/> Yes |
| Diabetes mellitus | <input type="radio"/> Yes | Diverticulitis | <input type="radio"/> Yes | Emphysema | <input type="radio"/> Yes |
| End-stage renal disease | <input type="radio"/> Yes | Hypertension | <input type="radio"/> Yes | Glaucoma | <input type="radio"/> Yes |
| Gout | <input type="radio"/> Yes | Heart murmur | <input type="radio"/> Yes | Heartburn | <input type="radio"/> Yes |
| Jaundice | <input type="radio"/> Yes | Mitral valve regurgitation | <input type="radio"/> Yes | Mitral valve stenosis | <input type="radio"/> Yes |
| Renal failure | <input type="radio"/> Yes | Sleep apnea | <input type="radio"/> Yes | Stroke | <input type="radio"/> Yes |

If you have history not listed above please write them here: _____

Surgical History

- | | | | | | |
|--------------------|---------------------------|-------------------------|---------------------------|------------------|---------------------------|
| Hernia repair | <input type="radio"/> Yes | Vasectomy | <input type="radio"/> Yes | Gallbladder | <input type="radio"/> Yes |
| Appendectomy | <input type="radio"/> Yes | Tonsillectomy | <input type="radio"/> Yes | Cesarean section | <input type="radio"/> Yes |
| Pacemaker, cardiac | <input type="radio"/> Yes | CABG | <input type="radio"/> Yes | Hysterectomy | <input type="radio"/> Yes |
| Vascular bypass | <input type="radio"/> Yes | Varicose vein stripping | <input type="radio"/> Yes | thyroidectomy | <input type="radio"/> Yes |
| Cataract removal | <input type="radio"/> Yes | | | | |

If you have had a surgery not listed, write it here: _____

Hospitalization

Same as surgeries Yes

If you have been hospitalized for any other reason: _____