



**Washington Township  
Medical Foundation**

Part of Washington Hospital Healthcare System

Cardiothoracic Surgery  
39141 Civic Center Drive, Suite 335  
Fremont, CA 94538  
(510) 248-1400

**Patient Medical History Form**

Instructions: To provide you with the utmost quality of care, we request that you complete this form in its entirety.

**Medical and Social History**

**Chief Complaint**

**What is the main reason for your visit today?** (describe in detail)

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**Do you suffer from any of the following?**

**1. Heart and / or Blood Pressure Problems**

**If  YES, please specify...**

- High Blood Pressure
- Angina Pectoris
- Heart Attacks:  
*How many: \_\_\_\_\_ When? \_\_\_\_\_*
- Heart Failure
- Previous Coronary Stenting / Ballooning  
*When? \_\_\_\_\_*
- Previous Coronary Bypass Surgery:  
*When? \_\_\_\_\_*
- Heart Valve Problems
- Previous Heart Valve Operations  
*When? \_\_\_\_\_*
- Other Heart Problems?  
*Specify \_\_\_\_\_*

**2. Vascular Problems**

**If  YES, please specify...**

- Previous Stroke *or TIA*
- Previous Carotid Surgery (*neck*)  
*When? \_\_\_\_\_*
- Pain in your legs
- Non-healing wounds in your legs
- Previous Vascular Surgery  
*When? \_\_\_\_\_*
- Aortic Aneurysm
- Previous Aneurysm Surgery:  
*When? \_\_\_\_\_*

<b>3. Lung Condition</b>	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis / Pneumonia <input type="checkbox"/> Lung Surgery or Intervention <input type="checkbox"/> Other Lung Problems? <i>Specify</i> _____
<b>4. Diabetes, Thyroid</b>	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Treated by Insulin, <input type="checkbox"/> Treated by pills, <input type="checkbox"/> Treated by diet <input type="checkbox"/> Do you suffer from any complications? <i>Specify</i> _____ <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other Endocrine conditions? <i>Specify</i> _____
<b>5. High Cholesterol</b>	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> <input type="checkbox"/> Treated by Pills, <input type="checkbox"/> Treated by Diet <input type="checkbox"/> Is it a common problem in your family? <i>Specify</i> _____
<b>6. Gastrointestinal</b>	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> <input type="checkbox"/> Liver disease <input type="checkbox"/> Gastric / Duodenal Ulcers <input type="checkbox"/> Rectal Bleeding or Black Stools <input type="checkbox"/> Other Gastrointestinal Problems? <i>Specify</i> _____
<b>7. Kidney</b>	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> <input type="checkbox"/> Renal (Kidney) Failure <i>For how long?</i> _____ <input type="checkbox"/> Do you require dialysis? <i>For how long?</i> _____ <input type="checkbox"/> Do you have a functioning dialysis access in your arm? <input type="checkbox"/> Do you have an intravenous catheter for dialysis? <input type="checkbox"/> What are the days you require dialysis? <input type="checkbox"/> Mon, <input type="checkbox"/> Tue, <input type="checkbox"/> Wed, <input type="checkbox"/> Thurs, <input type="checkbox"/> Fri, <input type="checkbox"/> Sat <input type="checkbox"/> Do you have a peritoneal catheter for dialysis?
<b>8. Other</b>	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> <input type="checkbox"/> Have you been diagnosed with cancer? <i>Specify</i> _____

Do you use tobacco products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> Amount per day: _____ For how many years: _____
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Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If <input checked="" type="checkbox"/> YES, please specify...</b> Amount per day: _____ For how many years: _____
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### Past Surgical History

**What surgical procedures have you had?**

(List **all** procedures, and if possible include the dates.)

1.

2.

3.

4.

5.

6.

### Prescribed Medications

**What medications are you currently taking?**

(List **all** pills, patches, and any other forms of prescribed medications.)

1.

**Dose:**

2.

**Dose:**

3.

**Dose:**

4.

**Dose:**

5.

**Dose:**

6.

**Dose:**

### Allergies

**What medications, food, or misc. substances are you allergic to?**

(Please describe type of reaction.)

1.

**Reaction:**

2.

**Reaction:**

3.

**Reaction:**

### General Anesthesia

**Have you ever had procedures under general anesthesia?**

Yes

No

**If  YES, did you have any adverse reaction?**

*Specify* \_\_\_\_\_