



Andrew J. Gresko, MD, FACC

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Acct# _____

Patient History Form

Patient Name: _____

Referring MD: _____

Date of Visit: _____

Age: _____ Male Female

Medication Allergies:

Are you allergic to seafood, shellfish, iodine or IVP dye? _____

Medications: (Please bring your medication bottle(s) to office visit**)**

Do you take an aspirin daily? 81 mg or 325 mg? _____

Do you have Nitroglycerine tablets or spray? _____

Please list all medications:

Drug	Dosage	Times taken daily	Drug	Dosage	Times taken daily
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Past Medical History:

- Coronary Artery Disease Yes No
- Congestive Heart Failure Yes No
- Heart valve disease Yes No
- Arrhythmia or an abnormal heart rhythm Yes No
- High Cholesterol Yes No
- Diabetes Yes No
- High Blood Pressure Yes No
- Kidney Disease Yes No
- Stroke Yes No
- Cancer Yes No
- Peripheral Vascular disease Yes No
- Thyroid Disease Yes No
- Lung Disease Yes No

Please list previous surgeries and dates:

Family History:

- Mother: Living Deceased Age: _____
Heart disease Yes No
- Father: Living Deceased Age: _____
Heart disease Yes No
- Brothers: Living Deceased Ages: _____
Heart disease Yes No
- Sisters: Living Deceased Ages: _____
Heart disease Yes No

Social History:

- Do you smoke? Yes No
- Date that you quit smoking _____
- How many years have you smoked? _____
- How many packs per day? _____
- Do you drink alcohol/beer? Yes No
- How much? _____
- Single Married Divorced Widowed
- # of Children _____ Grandchildren _____
- # of Great-Grandchildren _____
- Where were you born? _____
- What is your occupation? _____
- If retired, what was your occupation prior to retirement? _____
- When did you move to this area? _____