

# MOHAMED S. RAHMAN, M.D.

Board Certified Electrophysiologist & Cardiologist

## **Cardiac Procedure History**

Have you ever had any of the following?

Stress Test: Y / N

When: \_\_\_\_\_

Heart Catheterization: Y / N

When: \_\_\_\_\_

Heart Ultrasound (Echo): Y / N

When: \_\_\_\_\_

Stent/Other Coronary therapy: Y / N

When: \_\_\_\_\_

Coronary Angiography: Y / N

When: \_\_\_\_\_

Valve Surgery: Y / N

When: \_\_\_\_\_

Electrophysiology Study: Y / N

When: \_\_\_\_\_

Pacemaker or Defibrillator: Y / N

When: \_\_\_\_\_

Other: \_\_\_\_\_

When: \_\_\_\_\_

Other: \_\_\_\_\_

When: \_\_\_\_\_

Healthy Heart Cardiology  
**Dr. Mohamed Rahman M.D.**

1093 Ross Clark Circle  
Dothan, AL 36303  
Phone: (334) 699-6396

109 Medical Park Dr Ste A  
Andalusia, AL 36420  
Phone: (334) 923-1771

1275 James Dr Ste A  
Enterprise, AL 36330  
Phone: (334) 475-2696

**Medical History:**

Please specify any other illness or medical conditions you have now or have had in the past:

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Please list any operations or injuries:

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If you are a woman, are you passed menopause? Y / N

At what age?

Do you take estrogen replacement? Y / N

Are you taking birth control pills? Y / N

**Allergies:**

Are you allergic to any medications: Y / N

Please list any medications you can not tolerate and what happens when you take them:

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**Medical History Continued**

Please circle any symptoms you are having now or had recently:

Constitutional:	Fever	Chills	Fatigue
Respiratory:	Shortness of Breath	Wheezing	Cough
Gastrointestinal:	Heartburn	Diarrhea	Constipation
Musculoskeletal:	Muscle aches	Muscle tenderness	Muscle Cramps
Dermatological:	Skin Ulcers	Rash	
Neurological:	Dizziness	Headaches	
Endocrinological:	Bleeding	Easy Bruising	
Psychiatric:	Anxiety	Depression	

Please List any other symptoms you are having now or have had recently:

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**Medical History Continued**

**Medications:**

*Please list your medications including non-prescription drugs, supplements, and any herbal, naturopathic, or homeopathic products/remedies. Include dose and strength as applicable.*

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**Family History:**

Coronary disease, Angina, Heart Attack or Cardiac Arrest? Y / N

If yes, did your father, brother, or sons have it before the age of 55: Y / N

If yes, did your mother, sisters, or daughters have it before the age of 55: Y / N

Please give age AND cause of death, if known for:

<i>Family Member</i>	<i>Cause of Death</i>	<i>Age</i>
Mother:		
Father:		
Brother(s)/ Sister(s):		

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