ZACCAGNINI MEDICAL ASSOCIATES

Patient Name_____ Date_____

Past Medical History

	Do you have or have you ever had: YES	NO
Hypertension (elevated blood pressure)	_____	_____
Coronary artery disease (stents, bypass, MI)	_____	_____
High cholesterol or triglycerides	_____	_____
Heart Valve Issues (leakage or stiffness)	_____	_____
Artificial heart valves, pacemaker, defibrillator	_____	_____
Congestive heart failure	_____	_____
Stroke	_____	_____
Diabetes (type 1 or type 2)	_____	_____
Thyroid (hypo or hyper)	_____	_____
Other hormonal or endocrine disorders	_____	_____
GERD (heartburn, indigestion, hiatal hernia)	_____	_____
Liver disease (fatty liver, cirrhosis, jaundice)	_____	_____
COPD, emphysema, asthma	_____	_____
Pneumonia, tuberculous, lung infection	_____	_____
Kidney disease or stones	_____	_____
Prostate disorders	_____	_____
Cancers (type)_____	_____	_____
Receive chemotherapy or radiation treatments	_____	_____
Arthritis (Osteo or rheumatoid)	_____	_____
Osteoporosis	_____	_____
Chronic headaches (migraines)	_____	_____
Seizures	_____	_____
Sleep apnea (CPAP, dental appliance, untreated)	_____	_____
Depression	_____	_____
Anxiety	_____	_____
Anemia	_____	_____
Bleeding disorders	_____	_____
Polycystic Ovarian Syndrome	_____	_____

OTHER_____

Surgical History

List any surgeries_____

_____

Social History

Drink caffeine: amount_____	_____	_____
Drink alcohol: amount_____	_____	_____
Smoke cigarettes:amount_____	_____	_____
Use illicit/illegal drugs: type_____	_____	_____