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Patient History

Phone Nummber:_____

Patient Name: _____ Date of Birth: _____

Appointment is _____@_____ Referring Physician: _____

Reason for Referral: _____

PLEASE READ ALL OF THE INFORMATION BELOW AND FILL IN ALL BLANKS WITH AS MUCH INFORMATION AS POSSIBLE (DATES, AGES, ETC.).

Cardiac Risk Factors: (Please check YES or NO)

Have YOU, the patient, ever had any of the following:

Stroke/Mini-Strokes/TIA?	☐YES	☐NO	When? _____
Heartattack?	☐YES	☐NO	When? _____
Leg Artery Blockage?	☐YES	☐NO	When? _____
Diabetes?	☐YES	☐NO	When? _____
High Blood Pressure?	☐YES	☐NO	When? _____
High cholesterol?	☐YES	☐NO	When? _____
Family History of Heart Disease? (Before the age of 60)	☐YES	☐NO	Who? _____

Use TOBACCO? ☐YES ☐NO / Never ☐No, I quit

What type? ☐Cigarettes ☐Cigars ☐Dip ☐Chew ☐ All Types

How much per day? _____ How many years?_____ When did you quit?_____

FEMALES ONLY:

Completed/going through Menopause?	☐YES	☐NO	When? _____
Partial OR Complete Hysterectomy?	☐YES	☐NO	When? _____
Hormone Replacement Therapy?	☐YES	☐NO	When? _____

Medical History: (Please check YES or NO and give details: when, where, etc.)

Have YOU, the patient, had any of the following:

A Fib or other heart rhythm problem?	☐YES	☐NO	_____
EKG (electrocardiogram)?	☐YES	☐NO	_____
Mammogram?	☐YES	☐NO	_____
Stress Testing	☐YES	☐NO	_____
Echocardiogram (Ultrasound of Heart)?	☐YES	☐NO	_____
Colonoscopy?	☐YES	☐NO	_____
Heart Catheterization? Stent Placement?	☐YES	☐NO	_____
Colon Disease, Constipation, IBS, Crohn's Disease?	☐YES	☐NO	_____
Heart Surgeries (Bypass, ICD or valve replacement?	☐ Yes	☐ No	_____
Diabetes? Type 1 or Type 2	☐YES	☐NO	
Carotid Ultrasound?	☐YES	☐NO	_____
Carotid Endarterectomy? (Left or Right)	☐YES	☐NO	_____
Thyroid problems?	☐YES	☐NO	_____
Infectious Disease such as HIV?	☐YES	☐NO	_____
GERD or Acid Reflux?	☐YES	☐NO	_____
Bypass surgery of leg arteries?	☐YES	☐NO	_____

******* In order to avoid delays, please obtain your records BEFORE your appointment. This is your responsibility. *******

Medical History: (Please circle any problem that YOU, the patient may have/had)

Anemia Anxiety Asthma Bladder Problems Bleeding Diathesis Cancer (type) _____

Carpal Tunnel Syndrome Colon Polyps Depression DVT (blood clot in leg) Dialysis Fibromyalgia

Gallbladder Problems Gastroesophageal Reflux Gastrointestinal Disease Glaucoma Gout Liver Problems Kidney

Stones Obstructive Sleep Apnea / CPAP Osteoarthritis Other: _____ Psychiatric Disorder Lung Problems

PTE (blood clot in lungs) Kidney Problems Rheumatic Fever Rheumatoid Arthritis Scarlet Fever Scoliosis

Thyroid Disease Tuberculosis ☐**NONE**

Surgical History: (Please include approximate dates)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Most recent Influenza Vaccination/Pneumonia – When/Where? _____

Allergies: (Please check Yes or No and what type of reaction did you have?)

Shellfish	☐YES	☐NO	_____
Iodine	☐YES	☐NO	_____
IVP Dye	☐YES	☐NO	_____
Latex	☐YES	☐NO	_____
Food	☐YES	☐NO	_____
			_____
Drugs	☐YES	☐NO	_____
			_____
			_____

Current Pharmacy? _____

Current Medications:

Please include all Insulin, over the counter medications/vitamins/herbs and their strengths and how often you take each of them.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History: (Please fill out all areas COMPLETELY)

Relative	AGE(s)			Explanation
Father	_____	☐Living	☐Deceased	_____
Mother	_____	☐Living	☐Deceased	_____
Brother(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
Sister(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
Daughter(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
Son(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____

Social History: (Please check all that apply)

Are YOU, the patient?

☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

☐Live alone ☐Live with Family / Friend / Other Number of People in house is _____

In School - Where?_____

Working - Where & Type? _____ How long? _____

Retired - From? _____ How long? _____

Disabled - Why? _____ How long? _____

Do YOU, the patient:

Use ILLEGAL DRUGS ☐YES ☐NO, Never ☐NO, I quit What type? _____

How often? ☐Daily ☐Weekly ☐Monthly ☐Socially ☐Rarely

How many years? _____ When did you quit?_____

Use ALCOHOL ☐YES ☐NO, Never ☐NO, I quit

What type? ☐Beer ☐Wine ☐Whiskey ☐ALL TYPES

How often? ☐Daily ☐Weekly ☐Monthly ☐Socially ☐Rarely

How many years? _____ When did you quit?_____

Intake CAFFEINE? ☐YES ☐NO, Never ☐NO, I quit

TYPE: Coffee - how much? _____ Tea - how much? _____

Soda - how much? _____ Chocolate - how much? _____

ADVANCED DIRECTIVE:

Living Will ☐YES ☐NO _____

Organ Donor ☐YES ☐NO _____

Do you see other providers that may be prescribing you medications that you are currently on?_____
If yes which medications and what is the providers name?_____

Who is your current provider or who have you seen in the past 6-12 months for your healthcare?_____