



Samantha E Pickett CRNP FNP-C Phone:334-475-2680
Dr. Charles Linguiti Fax: 855-583-3701
806 Glover Ave Ste A
Enterprise, AL 36330

Patient History

Phone Number: _____

Patient Name: _____ Date of Birth: _____

Email: _____ @ _____ Insurance: _____ Contract # _____ Group # _____

Where did you here about our clinic: _____

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-Stroke/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. ******

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

☐ NONE[illegible]

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

Drugs	☐ YES	☐ NO	_____

[illegible]

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 quitWhat type? ☐Beer☐Wine☐Whiskey☐ALL TYPESHow 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? _____