

PATIENT HISTORY FORM

Date: _____

Name: (First) _____ (Middle) _____ (Last) _____

Address: _____

City _____ State _____ Zip _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Alternate Address (Summer/Winter) _____

City _____ State _____ Zip _____

Summer/Winter Phone: (_____) _____

Alternative Phone Contact (optional) _____ Relationship _____

Birth Date: ____/____/____ Social Security # _____ - _____ - _____

Sex: M F Marital Status: S M W D

Employer: _____

Employer's Address: _____

Primary Insurance: _____ Group #: _____

Subscriber's Name: _____ Contract #: _____

Subscriber's Date of Birth _____

Secondary Insurance: _____ Group #: _____

Subscriber's Name: _____ Contract #: _____

Emergency Contact Person: _____

Phone #: _____ Relationship: _____

Name of Dr who referred you to our practice? _____

Address _____

Phone _____

Please explain why you are coming to see the doctor. _____

Please list names, addresses and phone numbers of current physicians:

INTERNIST/FAMILY PHYSICIAN

CARDIOLOGIST

Send Records to above

Send Records to above

Please list any allergies to medications and type of reaction:

Have you ever had:

- Heart Attack Y or N List date(s): _____
- Heart Catheterization Y or N List date(s): _____
- PTCA/Angioplasty Y or N List date(s): _____
- Stent Placement Y or N List date(s): _____

Do you have a history of:

- | | | | |
|--------|-------------------------------|--------|---------------------|
| Y or N | Congestive Heart Failure | Y or N | High Blood Pressure |
| Y or N | Irregular Heart Rhythm | Y or N | High Cholesterol |
| Y or N | Heart Valve Disease | Y or N | Rheumatic Fever |
| Y or N | Asthma/Lung Disease | Y or N | Stomach Ulcer |
| Y or N | Cancer | Y or N | Diabetes |
| Y or N | Claudication/Vascular Disease | Y or N | Stroke/TIA |
| Y or N | Kidney Disease/Renal Failure | Y or N | Thyroid Dysfunction |

Please list major surgeries with dates:

Do you currently smoke? Y or N

If yes: How many packs a day? _____

How long have you been smoking? _____

If no: Have you ever smoked and when did you quit? _____

How much alcohol do you consume on a weekly basis and what type?

Amount: _____ Type: _____

Do you exercise on routine basis? Y or N What type: _____

For Female patients:

Are you post-menopausal? Y or N

If yes: Are you currently taking hormone replacement therapy? Y or N

Do your parents, grandparents, or siblings have a history of:

Y or N Heart attack Y or N Diabetes

Y or N Stroke Y or N Cancer

Please list *all* prescription and over-the-counter medication(s) you are currently taking;
the dose(s) and how many times a day you take them:

Name	Dose	Frequency	Name	Dose	Frequency
_____			_____		

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



Are you currently experiencing:

	Yes	No	Please Explain:
Shortness of breath?	_____	_____	_____
-at rest	_____	_____	_____
- with exercise	_____	_____	_____
- lying flat	_____	_____	_____
Chest pain (arm, jaw, etc.)	_____	_____	_____
- at rest	_____	_____	_____
- with exercise	_____	_____	_____
Dizziness	_____	_____	_____
Rapid heart rate/palpitations	_____	_____	_____
Swelling in feet or legs	_____	_____	_____
Pain in legs when walking	_____	_____	_____
Blood in urine/stool	_____	_____	_____
Nausea	_____	_____	_____

Thank you for taking the time to fill out this form in its entirety.

Patient Signature: _____ **Date:** _____