



Name: _____ DOB: ____/____/____ Today's Date: ____/____/____

Cell or Home Phone Number: (____) ____-____ Email: _____

What is the main reason for your visit? (i.e. check up) _____

Were you referred by another doctor? Yes No If yes, who? _____

Do you have a primary care doctor? Who? _____ or None

Who, if any, are the specialists you see? _____

How did you hear about us? (Circle one) Physician Referral, Friend/Relative, Internet Search

Other: _____

Recent Symptoms

- 1. Do you have chest pain? Yes No
2. Do you have shortness of breath? Yes No
a. If yes, with exertion? Yes No
b. If yes, while lying flat in bed? Yes No
c. If yes, does it wake you at night? Yes No
3. Have you had swelling in your legs? Yes No
4. Do you routinely develop pain in your legs when you walk? Yes No
5. Have you passed out recently? Yes No
6. Have you felt your heart beating fast or skipping for no reason? Yes No

Past Medical History

Table with 3 columns: Problem, Year Diagnosed, Yes, No. Rows include High Blood Pressure, High Cholesterol, Diabetes, Heart Attack, Heart Failure.

Past Surgical History

Table with 3 columns: Type of Surgery, Year of Surgery, Yes, No. Rows 1, 2, 3.

Family Medical History

Do heart attacks run in your family? Yes No
If so, who, and at what age did they have it?

Please list any health concerns (especially cardiac) of your:

- Father: (Alive or Deceased?)
Mother: (Alive or Deceased?)
Paternal Grandparents: (Alive or Deceased?)
Maternal Grandparents: (Alive or Deceased?)
Siblings: (Alive or Deceased?)

Social History

1. Do you currently smoke? Yes No Never Number of packs per day: _____

• If no, how long ago did you quit? _____

2. Do you exercise routinely? Yes No Type: _____

3. Do you currently drink caffeine? Yes No Number of drinks per day: _____

4. Do you currently drink alcohol? Yes No Number of drinks per day: _____

5. Occupation: _____

• Or, circle one: Retired Unemployed Disabled

Please list your current medications below (or write 'none' if appropriate):

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>
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Please list any medication allergies below (or write 'none' if appropriate):

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What Pharmacy do you use? Please provide address and phone number if known:

Review of Recent Symptoms: Circle all that apply or circle "None"

Constitutional: None

Fevers

Endocrine: None

Fatigue

Gastrointestinal: None

Abdominal Pain

Black (tar colored) stool

Musculoskeletal: None

Muscle aches

Neurology: None

Weakness in arms or legs

Visual Changes

Psychiatric: None

Depression

Genitourinary: None

Lack of sexual function (impotence)