Preventive Cardiology Consultants

NEW PATIENT INFORMATION

DATE:___/___/___

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

PLACE YOU WORK _____ OCCUPATION _____ HOW LONG _____

HOW WOULD YOU LIKE US TO CONTACT YOU: HOME: _____

WORK: _____

CELL: _____

FAMILY HISTORY

	LIVING		PRESENT HEALTH OR CAUSE OF DEATH
FATHER	__ YES __ NO	AGE AT DEATH_____	_____
MOTHER	__ YES __ NO	AGE AT DEATH_____	_____
SPOUSE	__ YES __ NO	AGE AT DEATH_____	_____

BROTHERS	NO. LIVING _____	HEALTH	_____
	NO. DECEASED _____	CAUSE OF DEATH	_____
SISTERS	NO. LIVING _____	HEALTH	_____
	NO. DECEASED _____	CAUSE OF DEATH	_____
CHILDREN LIVING	_____	AGES AND HEALTH:	_____
CHILDREN DECEASED	_____	AGES & CAUSES:	_____

PAST MEDICAL HISTORY

PREVIOUS OPERATIONS – LIST:	DATE	HOSPITAL (NAME/CITY)	SURGEON
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

HAVE YOU HAD SERIOUS ILLNESS, HEART ATTACK, ANGIOGRAM, HOSPITALIZATION? – LIST:

	DATE		DATE
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

PAST ILLNESSES: PLEASE CIRCLE IF <u>YOU</u> HAVE HAD:

DIABETES	SWALLOWING PROBLEMS	ASTHMA	UTERUS/OVARY PROBLEM	GLAUCOMA
HIGH CHOLESTEROL	STOMACH ULCERS	PNEUMONIA	ARTHRITIS/RHEUMATISM	BLOOD TRANSFUSION
HIGH BLOOD PRESSURE	JAUNDICE	KIDNEY STONES	BROKEN BONE(S)	BLEEDING DISORDER
CIRCULATION PROBLEMS	HEPATITIS	KIDNEY FAILURE	STROKE	THYROID PROBLEMS
VEIN TROUBLE	GALLSTONES	URINARY INFECTION	SEIZURE	TUBERCULOSIS
HEART MURMUR	COLON PROBLEMS	PROSTATE PROBLEMS	NERVOUS DISORDER	RHEUMATIC FEVER
SHORTNESS OF BREATH	HEARTBURN	CANCER	SKIN DISORDER	PALPITATIONS

ANY OTHER ILLNESSES/INFECTIONS/HEALTH CONCERNS:

_____

_____

PLEASE CIRCLE ILLNESSES PRESENT IN ANY BLOOD RELATIVE:

HEART DISEASE	HIGH BLOOD PRESSURE	CANCER	NERVOUS ILLNESS	ALLERGY
DIABETES	STROKE	KIDNEY DISEASE	BLEEDING TENDENCY	TUBERCULOSIS
HIGH CHOLESTEROL	LIVER DISEASE	ANESTHESIA COMPLICATIONS		

ALLERGIES:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, FOOD, OR IV DYE – LIST:

	DESCRIBE REACTION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

MEDICATIONS:

PLEASE LIST ALL MEDICATIONS, VITAMINS AND NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING (INCLUDING DOSAGE):

1. _____	11. _____
2. _____	12. _____
3. _____	13. _____
4. _____	14. _____
5. _____	15. _____
6. _____	16. _____
7. _____	17. _____
8. _____	18. _____
9. _____	19. _____
10. _____	20. _____

SUBSTANCE USE:

	CURRENT USE	PREVIOUS USE	TYPE/AMOUNT/FREQUENCY	HOW LONG (YEARS)	WHEN QUIT
TOBACCO	___ YES ___ NO	___ YES ___ NO	_____	_____	_____
CAFFEINE	___ YES ___ NO	___ YES ___ NO	_____	_____	_____
ALCOHOL	___ YES ___ NO	___ YES ___ NO	_____	_____	_____
STREET DRUGS	___ YES ___ NO	___ YES ___ NO	_____	_____	_____

IMMUNIZATIONS:

HAVE YOU BEEN IMMUNIZED AGAINST:

MEASLES	___ YES ___ NO	HEPATITIS	___ YES ___ NO	TETANUS	___ YES ___ NO; WHEN _____
MUMPS	___ YES ___ NO	POLIO	___ YES ___ NO	INFLUENZA	___ YES ___ NO; WHEN _____
RUBELLA	___ YES ___ NO			PNEUMONIA	___ YES ___ NO; WHEN _____

ANY OTHER INFORMATION YOU FEEL MAY BE PERTINENT:

_____

_____

_____

_____

_____

_____