Patient History Form

Name: _____ Date of Birth: _____

Appointment Date: _____

Please list all doctors you see:
Doctor's Name_____ ___ __Phone #_____ Type of Doctor_ _____

Describe the main problem/reason for visit: _____

Review of Systems:
Have you recently had any of the following? PLEASE CIRCLE YES OR NO.

Fatigue	Yes	No	Limb Swelling/Edema	Yes	No	Memory Loss	Yes	No
Fever	Yes	No	Passing out	Yes	No	Limb Pain	Yes	No
Blurred Vision	Yes	No	Shortness of Breath	Yes	No	Joint Pain	Yes	No
Eye Pain	Yes	No	Cough	Yes	No	Weight Loss	Yes	No
Headache	Yes	No	Wheezing	Yes	No	Weight Gain	Yes	No
Hearing Loss	Yes	No	Nausea	Yes	No	Depression	Yes	No
Vertigo/Lightheaded	Yes	No	Heartburn	Yes	No	Anxiety	Yes	No
Chest Pain	Yes	No	Muscular Weakness	Yes	No	Easy Bleeding	Yes	No
Heart Palpitations	Yes	No	Seizure	Yes	No	Easy Bruising	Yes	No
Irregular Heart Beats	Yes	No	Loss of Balance	Yes	No			

Please List Previous Surgeries/ Procedures:
Surgery_____ _____ __Date_____ _____Physician_____

Cardiology Procedure_____ ___ _Date_____ ___Physician_____

Peripheral Vascular Procedure__ __ Date_____ _____Physician_____

Do you have a pacemaker, ICD, or any other cardiac device implanted?

Device Type	Date of Implant	Physician	Device Company

Past Medical History:
Have you ever had any of the following conditions?
PLEASE CIRCLE YES OR NO.

			Date of Onset				Date of Onset
Asthma	Yes	No	/	High Blood Pressure	Yes	No	/
COPD(Emphysema/Chronic Bronchitis)	Yes	No	/	High Cholesterol	Yes	No	/
Erectile Dysfunction (ED)	Yes	No	/	Angina/Chest Pain	Yes	No	/
Sleep Apnea	Yes	No	/	Heart Attack	Yes	No	/
Diabetes	Yes	No	/	Heart Murmur	Yes	No	/
Insulin	Yes	No	/	Palpitations	Yes	No	/
Thyroid Disease	Yes	No	/	Atrial Fibrillation	Yes	No	/
Underactive (Hypo)	Yes	No	/	Peripheral Vascular Dz	Yes	No	/
Overactive (Hyper)	Yes	No	/	Leg Pain/cramps	Yes	No	/
Stomach Ulcers/GERD	Yes	No	/	Hepatitis	Yes	No	/
Cancer (Where?)	Yes	No	/	Rheumatic Fever	Yes	No	/
Scarlet Fever	Yes	No	/	Stroke/TIA	Yes	No	/
Seizures	Yes	No	/	Arthritis/Gout	Yes	No	/
Bleeding Problems	Yes	No	/	Kidney Disease	Yes	No	/

Do you have any allergies to drugs or food? **Yes** **No** (circle one)

Allergic to:	**Reaction**:

List all medications you are taking:

Medication Name	Dosage	How often taken?	Who prescribed?

- **Please Remember to bring all medications with you to your appointment**.

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Family Medical History:
Has anyone in your immediate family (your FATHER, your MOTHER, your BROTHERS, your SISTERS, and/or your CHILDREN) had any of the following?

Coronary Artery Disease	Yes	No	If yes, who? _____	At age? _____
Diabetes	Yes	No	If yes, who? _____	At age? _____
Heart Attack	Yes	No	If yes, who? _____	At age? _____
High Blood Pressure	Yes	No	If yes, who? _____	At age? _____
High Cholesterol	Yes	No	If yes, who? _____	At age? _____
Sudden Death	Yes	No	If yes, who? _____	At age? _____

Social History:
How many alcoholic beverages do you drink in an average week? _____
Do you currently smoke tobacco? **Yes, No** Do you currently chew tobacco? **Yes No**
How much **do** you smoke? _____ How long have you smoked? _____
If you quit smoking, when did you quit? _____ How much **did** you smoke? _____
How many years did you smoke before quitting? _____
Are you on a special diet? **Yes, No** If yes, what type of diet? _____
How many cups of caffeinated beverages do you drink on an average day? _____
Do you exercise on a regular basis? **Yes No**
Do you have a history of drug dependency? **Yes, No** If yes, specify _____
Are you: Single_____ Married_____ Divorced_____ Widowed_____
How many children do you have? _____
What was the highest grade of formal education that you finished? _____
Your occupation _____ How many hours per week do you work? _____
Is there any heavy physical exertion while working? **Yes No**
If yes, what? _____

I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

_____ _____
Signed Date

Note: This authorization is not valid unless signed and dated and will remain in effect until you notify us otherwise.