New Patient Medical History Form

Patient Name:
D.O.B.

Reason you made your appointment today:

☐Abnormal testing ☐ Need New Cardiologist ☐ Shortness of Breath

☐Pre operative evaluation ☐Palpitations ☐ Chest Pain

☐ Primary Doctor referred you ☐ Other: Please explain below

_____

_____

_____

Childhood diseases:		Liver Disease	Yes☐
Rheumatic fever	Yes ☐	Gallbladder disease	Yes☐
Chicken pox	Yes ☐	Kidney disease	Yes☐
Scarlet fever	Yes ☐	Colon disease	Yes☐
Measles	Yes ☐	Lung Disease	Yes☐
Mumps	Yes ☐	Peptic ulcer disease	Yes☐
Whooping cough	Yes ☐	Heart burn	Yes☐
Heart murmur	Yes ☐	Varicose Veins	Yes☐
Other Illnesses:		Anemia	Yes☐
Migraine Headaches	Yes ☐	Blood Disorder	Yes☐
Autoimmune Disease	Yes ☐	Thyroid Disorder	Yes ☐
Cancer			

Other illnesses cont:

Enlarged heart	Yes ☐	If yes, when diagnosed: ____ / ____ / _____ mm dd yyyy
Hypertension	Yes ☐	If yes, when diagnosed: ____ / ____ / _____ mm dd yyyy
Diabetes	Yes ☐	If yes, when diagnosed: ____ / ____ / _____ mm dd yyyy
Irregular heartbeat	Yes ☐	If yes, when diagnosed: ____ / ____ / _____ mm dd yyyy
Abnormal lipids (cholesterol/triglycerides)	Yes ☐	If yes, when diagnosed: ____ / ____ / _____ mm dd yyyy
History of Stroke	Yes ☐	If yes, when diagnosed: ____ / ____ / _____ mm dd yyyy

Social History:

Smoking	Yes ☐ No☐	Packs per day_____ For how many years_____ Former Smoker: Quit_____
Alcohol	Yes ☐ No☐	Never ☐ Rare ☐ Occasionally ☐ Heavy ☐
Caffeine	Yes ☐ No☐	If Yes: How many cups per day_____
Recreational Drugs	Yes ☐ No☐	☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other _____

Have you ever had surgery? Yes☐ No ☐ if yes Please Explain briefly

_____

_____

_____

Previous Cardiac Testing: Please send before appointment or bring records with you to first appointment.

Test	**When**	**Where**
EKG		
Treadmill Stress Test		
Nuclear Stress Test		
Heart Catheterization		
Cardiac STENT		
Echocardiogram		
Carotid Ultrasound		
Other:_____		

Family History:

Relation	**Age**	**Deceased/Cause**	**History:** **Stent, Bypass, Sudden Death, Aneurysm, Stroke, Heart attack, Diabetes, High blood pressure, etc.**
Mother			
Father			
Brothers and Sisters	**Age**	**Deceased/Cause**	**Stent, Bypass, Sudden Death, Aneurysm, Stroke, Heart attack, Diabetes, High blood pressure, etc.**
1.			
2.			
3.			
4.			
5.			
Children	**Age**	**Deceased/Cause**	**Stent, Bypass, Sudden Death, Aneurysm, Stroke, Heart attack, Diabetes, High blood pressure, etc.**
1.			
2.			
3.			
4.			

Medications: Please list *all* prescriptions, over the counter medications and herbal supplements

Name of Medication	**Strength**	**How often taken**	**Name of Medication**	**Strength**	**How often taken**
1.			11.		
2.			12.		
3.			13.		
4.			14.		
5.			15.		
6.			16.		
7.			17.		
8.			18.		
9			19.		
10.			20.		

Please bring all medications (inhalers, insulin, pills) prescribed, over the counter and herbal supplements with you to all of your appointments.