NEW PATIENT MEDICAL AND FAMILY HISTORY

Patient's full legal name: _____ Social Security #: _____

Are you allergic to any medications or foods: _____ YES _____ No
If Yes, please list: _____

Please list ALL of the medications that you are currently taking:

Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____

Please list ALL of your surgical procedures:

Procedure: _____Year: _____ Procedure: _____ Year: _____

Procedure: _____ Year: _____Procedure: _____ Year: _____

If you have experienced any of the below, Please CIRCLE it:

Anemia
Gout
Stroke
Breathing Difficulties
Heart Palpitations
Heart Murmur
Abnormal EKG
Rheumatic fever
High Blood Pressure
Angina
Heart Attack
Overweight
Hiatal Hernia
Arthritis
Gallbladder problems
Thyroid Problems
Kidney Problems
Ulcers
Bowel Problems
Psychiatric Problems
Liver Problems
Other- please specify: _____

Have you ever had:

Diabetes
If yes, controlled by_____
High Cholesterol
If yes, count & when_____
Stress Test
If yes, when & where_____
Nuclear Stress Test
If yes, when & where_____
Cardiac Catheterization
If yes, when & where_____
PTCA (Angioplasty)
If yes, when & where_____
Cardiac Bipass Surgery
If yes, when & where_____
Pacemaker
If yes, when & where_____
Heart Valve Replacement
If yes, when & where_____
Defibrillator Implant
If yes, when & where_____

Do you CURRENTLY use tobacco? _____ YES _____ NO
If yes, please circle one or more: cigars cigarettes pipe chewing tobacco

Have you EVER used tobacco? _____ YES _____ NO
If yes, please circle one or more: cigars cigarettes pipe chewing tobacco
Please estimate your daily consumption of alcohol:
_____

FAMILY HISTORY

Is your father living? _____ YES _____ NO His age, or age at death: _____
Cause of death: _____
Is your mother living? _____ YES _____ NO Her age, or age at death: _____
Cause of death: _____
How many brothers do you have? _____ Number living:_____ Number deceased: _____
Ages and cause(s) of death: _____
How many sisters do you have? _____ Number living:_____ Number deceased: _____
Ages and causes(s) of death: _____
How many children do you have? _____ Ages: _____
Any health problems? _____ YES _____ NO If yes, of what nature? _____
How many grandchildren do you have? _____

If ANY of the following illnesses run in your family, please CIRCLE:

Diabetes Which family member? _____
Stroke Which family member? _____
Hypertension Which family member? _____
Heart Disease Which family Member? _____

IS THERE ANYTHING ADDITIONAL THAT WE SHOULD KNOW ABOUT YOUR HEALTH OR HISTORICAL BACKGROUND?
_____YES _____ NO
If yes, please explain:

EMERGENCY CONTACT PERSON: _____
PHONE # FOR EMERGENCY CONTACT: _____

Patient's PRINTED name (or legal guardian)

Patient or Legal Guardian Signature Date