

Please type into the fields on this form using your computer keypad. Once completed, print the form and bring it with you to your appointment.



Name: _____

Age: _____ Birthdate: _____

New Patient History Form

History of Present Illness

What is the reason for your visit? _____

Past Medical History

Heart Disease	Y	N	Other Medical Conditions: _____ _____ _____
Prior Heart Attack	Y	N	
Congestive Heart Failure	Y	N	
High Blood Pressure	Y	N	
Diabetes	Y	N	
High Cholesterol	Y	N	
Stroke	Y	N	
Blood Clots	Y	N	
Bad Reaction to Anesthesia?	Y	N	

Past Surgical History

Heart Bypass	Y	N	Other Surgeries: _____ _____ _____
Heart Stent	Y	N	
Arm or Leg Bypass	Y	N	

Current Medications		Allergies and Sensitivities	
		List any medications you are allergic to and how each affects you	
Name	Strength and Frequency	Allergic To	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physicians-Please list the doctors you currently see

Primary Care:	Date of last exam:
Cardiologist:	Date of last exam:
Other:	Date of last exam:

Family History

List any pertinent health conditions of immediate family members (i.e. stroke, heart attack)

Relative:	Condition(s)	Age
_____	_____	_____
_____	_____	_____

Social History

Marital Status: Single Married Divorced Widowed
Do you smoke? Y N _____ packs per day Prior smoker? Y N Year quit: _____
Alcohol use: Never Occasional Daily Recreational drug use? Y N
Occupation: _____ Retired: Y N

Review of Systems

Check the box for each symptom that you have now, or have had in the past.

Constitutional Symptoms

- Good general health lately
- Recent weight gain
- Recent weight loss
- Fever
- Fatigue

Eyes

- Glaucoma
- Cataracts
- Other eye disease
- Wear glasses/contact lenses
- Blurred or double vision

Ears/Nose/Mouth/Throat

- Hearing loss or ringing
- Earaches or drainage
- Chronic sinus problem
- Nose bleeds
- Tooth or gum infection
- Loose or damaged teeth
- Sore throat or voice damage
- Swollen glands in neck

Cardiovascular

- Mitral valve prolapse
- Chest pain or angina
- Palpitation
- Swelling feet/ankles
- Rheumatic Fever
- History of heart attack

Endocrine

- Thyroid problems
- Diabetes
- Hormonal problems
- Heat intolerance
- Cold intolerance

Gastrointestinal

- Hepatitis
- Peptic ulcer disease
- Abdominal pain
- Nausea or vomiting
- Frequent diarrhea
- Blood in stool

Genitourinary

- Poor kidney function
- Frequent urination
- Burning or painful urination
- Blood in urine
- Incontinence or dribbling
- Kidney stones

Women:

- Recurrent infections
- May be pregnant
- Postmenopausal

Men:

- Trouble getting an erection
- Prostate problems
- Have had a vasectomy

Musculoskeletal

- Arthritis
- New pain in bones or joints
- Muscle pain or cramps
- Back pain
- Difficulty in walking

Integumentary

- Varicose veins
- Rash
- Slow to heal

Neurological

- Frequent headaches
- Head injury
- Seizures
- Sudden blindness
- Stroke
- Fainting spells
- Weakness in limb

Respiratory

- Tuberculosis
- Asthma
- Emphysema
- COPD
- Frequent coughs
- Spitting up blood
- Shortness of breath
- Wheezing

Hematologic/Lymphatic

- Easy bleeding/bruising
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands
- Sickle cell anemia
- History of blood clots

Psychiatric

- Memory loss
- Depression
- Insomnia
- Nervousness
- Confusion