Patient History

Name:

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Personal Demographics

Name	
Date of Birth	
Gender	[ ] Male [ ] Female
Marital Status	
Race	[ ]Asian Black or African American [ ]Hispanic [ ]Multicultural [ ]White [ ]Other
Ethnicity	[ ]Hispanic or Latino [ ]Not Hispanic [ ]Unknown
Primary Language	[ ]English [ ]Chinese [ ]Polish [ ]Russian [ ]Spanish [ ]Other
Secondary Language	[ ]English [ ]Chinese [ ]Polish [ ]Russian [ ]Spanish [ ]Other
Occupation	
Referring Doctor	
Reason for Visit	

Tobacco use	[ ] Current. How many packs per day? _____ [ ] Former. How many packs per day? _____ Quit date? _____ [ ] Never
Alcohol use	[ ] Current. Heavy drinker?_____ How much do you drink?_____ [ ] Never.
Recreational drug use	[ ] Current [ ] Former [ ] Never
Caffeine use	[ ] Yes. What types of caffeine? _____ How much per day? _____ [ ] No.

Patient History

Name:

Cardiac Procedures

Test	Date	Where
Cardiac Catherization (Angiogram)		
Heart Stent		
EKG		
Stress Test		
Echocardiogram		
Heart Monitor		
Other Heart tests		

Previous Surgeries

	Date	Hospital
Bypass Surgery		
Valve Surgery		
Other:		

Medications

Medication Name	Dosage	How often

What pharmacy do you use? _____

Phone number: _____

Patient History

Name:

Allergies

Name of Medication	Allergic Reaction

Family History

Has someone in your family had the following medical problems?

	Yes/ No	Relationship to you:
Coronary artery disease		
Heart Failure		
Heart Attack If yes at what age?		
Stroke		
High Blood Pressure		
Diabetes		
Sudden Death		

Past Medical History

Have you had any of the following:

___ High blood pressure If yes, since when? _____
___ Diabetes If yes, since when? _____
___ Elevated Cholesterol If yes, since when? _____
___ Heart Attack If yes: date _____
___Heart Failure If yes: date _____
___Coronary Artery Disease
___Heart Valve Problems
___Carotid Artery Disease
___Blockage in leg arteries
___Stroke
___Asthma
___Cancer
___Sleep Apnea
___ Pulmonary Disease (COPD)
___ Thyroid Problems
___Other _____

Women:
Are you postmenopausal? [ ] Yes [ ] No
Have you had a hysterectomy? [ ] Yes [ ] No If yes, when? _____