PATIENT BACKGROUND INFROMATION

Patient Name ______________________________ **Date of Birth**______________**Today's Date** ______________

Age____ Sex____Height_____ Weight_____ Referring Physician ____

Reason for visit: Please check all that apply

□ Chest pain
□ Shortness of Breath
□ Palpitations (rapid heartbeat)
□ Dizziness
□ Passing Out
□ Swelling Feet

Allergies to Medicine(s): ____

Allergies to Food(s, Dye, Other: ____

Past Medical History___________________

□ Heart Attack
□ High Blood Pressure
□ Angina
□ Stroke
□ Diabetes Mellitus
□ High Cholesterol
□ Pacemaker _______Yes _______No
_/_/__Date of Implant Make or Model ____

Past Major Surgery

1. ____
2. ____
3. ____

Current Medications (please include name, dosage and how often you take each medication)

1. ________________________________ 5. ________________________________

2. _________________________________ 6. ________________________________

3. ________________________________ 7. ________________________________

4. ________________________________ 8. ________________________________

KEYSTONE CARDIOVASCULAR CENTER

PATIENT BACKGROUND INFROMATION

Patient Name ______________________________ Date of Birth______________Today's Date ______________

Personal History: (Please describe a typical day)

Smoking _______Yes _______No _______Duration _______Amount

Alcohol _______Yes _______No _______Duration _______Amount

Non-prescription Drugs _______Yes _______No _______Duration _______Amount

Exercise: What kind of exercise: Frequency: Duration:

Eating: How many meals: __________ When (approx. times of day: ___________________

Where: at home □ at restaurant □ How many snacks: _______________

Sleeping: What times of day/night: ______ How long: _____________________

Sexual Activity: □ active □ not active due to______________________________

□ Have questions/concerns now__________________________________

Family History:

□ Heart Attack or Sudden Death earlier than 65 years old	Father	Mother	Brother	Sister
□ Stroke	Father	Mother	Brother	Sister
□ Diabetes Mellitus	Father	Mother	Brother	Sister
□ Hypertension	Father	Mother	Brother	Sister
□ High Cholesterol	Father	Mother	Brother	Sister

Have you had any falls in the past 6 months? NO □ YES□ If yes, tell us what happened.

Who is your main caregiver? Myself□ Spouse/Significant Other□ Family Member□ Friend□ Health Professional□ Other□

Name of person checked__________________________________

Who lives in your home with you?

PATIENT BACKGROUND INFROMATION

Patient Name ______________________________ Date of Birth______________Today's Date ______________

Work History

Do you currently work? YES□ NO □

Job___________________________ □ retired □ homemaker
Employer______________________ □ unemployed

Location_______________________ □ on disability □ student

My biggest question now is:

Psychosocial Information
Are there any ethnic customs, religious requirement, or nationality preferences that influence your lifestyle? Please describe.