CONSULTANTS IN CARDIOLOGY & ELECTROPHYSIOLOGY LLC **Patient History**

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Name:_____Date:_____
(Last) (First) (Middle)

Patient phone: _____ Cell #: _____

Date of Birth:_____Age:_____Referring Doctor:_____Occupation:_____

MEDICAL HISTORY

Please list all the prescription and non-prescription medications you are currently taking:

MEDICATIONS	DOSE(mg)	FREQUENCY	START DATE

Do you have any allergies? YES( ) NO( ) If yes, please list them with type of reaction:

Please indicate whether or not you have had any of the following conditions:

INDICATE	YES	NO	INDICATE	YES	NO
CHEST PAIN / ANGINA			GOUT		
CORONARY ARTERY DISEASE			DIZZINESS / FAINTING		
HEART MURMUR			EPILEPSY		
HEART ATTACK			ANXIETY		
BYPASS SURGERY			GLAUCOMA / EYE DISORDERS		
ANGIOPLASTY (BALLOON)			THYROID DISEASE OR PROBLEM		
ROTOBLATOR			SHORTNESS OF BREATH		
STENT			ASTHMA		
HEART VALVE SURGERY			COPD / EMPHYSEMA		
CAROTID BLOCKAGE			PEPTIC ULCER		
LEG CIRCULATION PROBLEMS			PANCREATITIS		
STROKE / TIA			GALL BLADDER DISEASE		
CONGENITAL HEART DISEASE			LIVER DISEASE, JAUNDICE, HEPATITIS		
RHEUMATIC HEART DISEASE			INTESTINAL PROBLEM (COLITIS), ETC.		
CONGESTIVE HEART FAILURE			KIDNEY DISEASE		
HEART PALPITATIONS			URINARY PROBLEMS		
LEG PAIN WHILE WALKING			FATIGUE		
ANEURYSM			ANEMIA		
PACEMAKER OR DEFIBRILLATOR			BLEEDING DISORDER		

HIGH CHOLESTEROL			ARTHRITIS		
HIGH TRIGLYCERIDES			CANCER		
HIGH BLOOD PRESSURE			HIV / AIDS		
DIABETES			PSYCHIATRIC PROBLEMS		

Other: *(Please make any comments in regards to the above):*
Please list any other medical problems you may have: _____

Hospitalization History

Please list any hospitalizations within the last two years:

NAME OF HOSPITAL	DATE(S)	REASON FOR HOSPITALIZATION

Gynecological History *(Women only):*

Have you had a hysterectomy? YES( ) NO( )
Have you gone through menopause? YES( ) NO( ) Date of Last Menstrual Period
Do you take hormone replacement? YES( ) NO( )

Surgical History

NAME OF OPERATION	DATE	COMPLICATION (IF ANY)

Patient Profile

Do you smoke: YES( ) NO( ) Quit: _____ How long ago? _____
If yes or quit, how much do (or did) you smoke per day? _____
How long have *(or had)* you been smoking? _____

Do you drink alcoholic beverages? YES( ) NO( )
If yes, how many ounces do you average per week? _____Oz. Liquor _____Oz. Wine _____Oz. Beer

Do you use *(or have you used)* illegal drugs? YES( ) NO( )
Do you use *(or have you used)* intravenous drugs? YES( ) NO( )
Date last used: _____

Do you exercise regularly: YES( ) NO( ) How long/often?
What do you do? _____ How long: _____ How often?
How much caffeine do you consume daily? *(cups of coffee, tea, soda)*

Family History

Have any of your family members had any of the following problems:
(Please use (M) Mother, (F) Father, (S) Sister, (B) Brother, (C) Children)

PROBLEM	FAMILY MEMBER(S) AND AGE OF ONSET FOR EACH
STROKE	
HEART ATTACK	
HEART BYPASS SURGERY/ANGIOPLASTY/STENT	
DIABETES	
HIGH BLOOD PRESSURE	
CHOLESTEROL/TRIGLYCERIDES	
LEG CIRCULATION PROBLEMS	
CAROTID (NECK) BLOCKAGE	

Please add any pertinent family history: