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NAME	D.O.B.	GENDER	DATE

PRESENT HISTORY
Chest Pain:
Shortness of breath:
Dizziness/faintness/loss of consciousness:
Palpitations:
Other:

MEDICATIONS	
Name, Dose, Frequency	Name, Dose, Frequency
1-	5-
2-	6-
3-	7-
4-	8-

ALLERGIES	
1-	5-
2-	6-
3-	7-
4-	8-

PAST CARDIOVASCULAR HISTORY
High Blood Pressure:
High Blood Cholesterol/Triglycerides:
Diabetes/Pre-Diabetes:
Heart Attack/Coronary Artery Disease:
Congestive Heart Failure/Carddiomyopathy:
Arrhythmia:
Heart Murmur/Valve Issue:
Stroke/TIA:
Peripheral Vascular Disease:
Venous Insufficiency/DVT/Pulmonary Embolism:
Gout:
Erectile Dysfunction:
Other:

PAST MEDICAL HISTORY
Respiratory:
Gastrointestinal:
Kidney/Urinary:
Endocrine/GYN:
Musculoskeletal:
Neurological:
Dermatological:
Hematological/Lymphatic:
Allergy/Immunology:
Psychiatric:
Other:

PAST HOSPITALIZATIONS/SURGERIES/PROCEDURES (Including Colonoscopies/Endoscopies)	
1-	5-
2-	6-
3-	7-
4-	8-

FAMILY HISTORY
Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:

Social History	
Marital Status:	Children:
Occupation:	
Cigarette Smoking:	
Alcohol Intake:	
Caffeine Intake:	
Drug Usage:	
Dietary Habits:	
Activity/Exercise Habits:	
Stress Levels:	

HEALTH CARE PROXY:

LIVING WILL: