NAME:_____ TODAY'S DATE:_____

REFERRING M.D.:_____ DATE OF BIRTH:_____ SEX: Male / Female

CHIEF COMPLAINT:_____

Reason for consultation:_____

1. Do you have now or have you ever had any of the following:

Yes / No		Yes / No		Yes / No		Yes / No	
___ ___	Shortness of breath	___ ___	Chest Pain	___ ___	Shaking	___ ___	Frequent urination
___ ___	Asthma	___ ___	Slurred speech	___ ___	Visual disturbance	___ ___	Kidney problems
___ ___	Fluid in lungs	___ ___	Weakness	___ ___	Loss of vision	___ ___	Blood in urine
___ ___	Wheezing	___ ___	Stroke	___ ___	Blurred vision	___ ___	Arthritis
___ ___	Emphysema	___ ___	Fainting Spells	___ ___	Double vision	___ ___	Leg pain when walking
___ ___	Bronchitis	___ ___	Lightheadedness	___ ___	Weight loss	___ ___	Swelling of the ankles
___ ___	Difficulty breathing	___ ___	Headaches	___ ___	Weight gain	___ ___	Swelling of the legs
___ ___	Chronic cough	___ ___	Peptic ulcer	___ ___	Excessive thirst	___ ___	Varicose veins
___ ___	Cough up blood	___ ___	Constipation	___ ___	Diabetes	___ ___	Anxiety panic
___ ___	High blood pressure	___ ___	Liver disease	___ ___	Thyroid	___ ___	Depression
___ ___	Irregular heart beat	___ ___	Abdominal pain	___ ___	Fatigue	___ ___	Allergies
___ ___	Rheumatic fever	___ ___	Black stools	___ ___	Easy bruising	___ ___	Drug allergies
___ ___	Heart murmur	___ ___	Blood in stools	___ ___	Bleeding disorder	___ ___	Adverse drug reaction
___ ___	Enlarged heart	___ ___	Change in bowel habits	___ ___	Congestion	___ ___	Menstrual irregularities
___ ___	Heart attack	___ ___	Frequent bowel movements	___ ___	Nose bleeds	___ ___	Menopause (Date_____)
___ ___	Palpitation	___ ___	Cholesterol or lipid disorder	___ ___	Burning on urination	___ ___	Other_____
___ ___	Fluttering of the heart	___ ___	Awakened at night by shortness of breath				

PERSONAL AND FAMILY MEDICAL HISTORY

	Self	Father	Mother	Siblings	Children
Living or Deceased					
Age					
Anemia					
Arthritis					
Bleeding Disorder					
Cancer					
Chest Pain					
Depression					
Diabetes					
Epilepsy / Seizures					
Glaucoma					
Gout					
Headache/Migraines					
Heart Disease					
Hepatitis					
High Blood Pressure					
High Lipids					
Kidney Disease					
Mental Illness					
Prostate Disease					
Rheumatic Fever					
Stroke					
Thyroid Disease					
Ulcer					
Other					

PAST HISTORY: Have you ever had

	Date	Location
Cholesterol test		
Lab Work		
EKG		
Chest x-ray		
Exercise test (with imaging)		
Echocardiogram		
Cardiac Catheterization		
Pacemaker/ablation		
Cardiac surgery		

PAST HISTORY: Hospitalization (List with date & problem

Hospital	Date	Problem / Illness

SIGNIFICANT OPERATIVE OR INVASIVE PROCEDURES

Date	Reason

Updated April 3, 2014

NAME:_____ DATE OF BIRTH:_____ TODAY'S DATE:_____

ADVERSE / ALLERGIC DRUG REACTIONS	
Name of drug	**Reaction**

MEDICATIONS (Include any herbal and over the counter medications)		
Name	**Dosage**	**Directions / Times per day**

Social History: Habits / Risk Factors for Heart Disease

Smoke now? ___Yes ___No Ever smoked? ___Yes ____No
Packs daily?_____ How long?_____

Alcohol: __Yes ___No Type?_____ Amount?_____

Controlled substances? __Yes __No Type?_____

Stressful life style? ___Yes ___No

Sedentary life style? ___Yes ___No

Obesity? ___Yes ___No

Do you have an Advance Directive? ____Yes ____No

Do you have a Living Will? ____Yes ____No

Disability Status and Dates:_____

_____

_____

_____

Office Abbreviations:

PSU → Patient stated understanding
Δ → Change
R → Refills
M → Medications
A → Advised
Rx → medication therapy

C → Counseled
D → Discussed
E → Exacerbation
S → Surgery
H → Hospitalization
R → Reviewed

Physician Signature: Date:

Update 04/03/2014