Last Name _____

Reason for Today's Visit?

_____

_____

Recent Hospitalizations?

_____

Past Medical History

(Please check all that apply)

- ☐ Diabetes
- ☐ Hypertension
- ☐ Cholesterol
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Atrial Fibrillation
- ☐ Arrhythmia
- ☐ Lung Problems
- ☐ Smoker
- ☐ Other:_____

Past Surgical History

(Please check all that apply)

- ☐ Pacemaker Implant
- ☐ Valve Repair
- ☐ Valve REplacement
- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Cholecystectomy
- ☐ Herniorrhaphy
- ☐ Defibrillator Implant
- ☐ Bypass Surgery
- ☐ Other:_____

Family History

(Please check all that apply to IMMEDIATE family ONLY.)

	Relationship to Patient
☐ Heart Attack	_____
☐ Bypass Surgery	_____
☐ Angioplasty	_____
☐ High Blood Pressure	_____
☐ Diabetes	_____
☐ Cancer	_____

Last Name _____

Do you have any drug allergies?_____

Are you taking any daily vitamins or probiotics on a regular basis?_____

Pharmacy Name:_____

Address: _____Phone: _____

Please list all current medications you are taking:

Name	Dose	How Often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you give us permission to access your medication records from your current pharmacy?

Yes No

Have you had any recent diagnostic testing?

	Date	Where?	Normal?
Regular stress test	_____		
Nuclear Stress Test	_____		
Echocardiogram	_____		
Cardiac Catheterization	_____		
Stents/Angioplasty	_____		
Vascular Testing	_____		
Vascular Stents (LEGS)	_____		
Pacemaker Implant	_____		
Defibrillator Implant	_____		