New Patient History Form

NAME OF PATIENT: _____ DATE: _____
LAST FIRST

AGE: _____ DATE OF BIRTH: _____ SEX: M ☐ F ☐ HEIGHT: _____ FT_____IN. WEIGHT: _____

WHAT MEDICAL PROBLEM OR CONDITION ARE YOU HERE TO HAVE EVALUATED: _____

_____

ARE YOU ALLERGIC TO:	YES	NO	Please lists all allergies to medications and other substances? Describe reaction they cause:
ANY MEDICATIONS:	☐	☐	_____
IODINE, FISH OR SELFISH	☐	☐	_____
X-RAY DYE OR IV CONTRAST	☐	☐	_____
CAN YOU TOLERATE ASPIRIN	☐	☐	_____?

HAVE YOU TAKE ASPIRIN OR ASPIRIN LIKE PRODUCTS IN THE LAST 10 DAYS? (*MOTRIN, ADVIL, NUPRIN*) ☐ YES ☐ NO

IF YES, WHAT MEDICATION DID YOU TAKE? _____ WHEN DID YOU LAST TAKE IT? _____

ARE YOU ON A SPECIAL DIET? ☐ YES ☐ NO MALES ONLY: ARE YOU TAKING VIAGRA OR CIALIS? ☐YES☐ NO

CURRENT MEDICATIONS PRESCRIBED & NON-PRESCRIBED	DOSE (STRENGTH)	SCHEDULE (HOW MANY & TIMES PER DAY)	HOW LONG HAVE YOU TAKEN THEM
EXAMPLE: Cardizem	60mg	1 pill, 4 times a day	1 Month

DO YOU HAVE: YES NO

HIGH BLOOD PRESSURE ☐ ☐

DIABETES CONTROLLED

WITH: ☐ INSULIN ☐PILL ☐DIE

HOW LONG: _____

HISTORY OF SMOKING: ☐ YES ☐ NO

HIGH CHOLESTEROL ☐YES ☐ NO

FAMILY HISTORY OF HEART DISEASE OR VASCULAR DISEASE ☐YES ☐ NO

A SEDENTARY OR INACTIVE LIFESTYLE ☐YES ☐ NO

WEIGHT CONTROL PROBLEMS (OBESITY) ☐YES ☐ NO

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

DO YOU NOW OR HAVE EVER SMOKED TOBACCO PRODUCTS? YES NO

CIGARETTES # OF PACKS PER DAY: _____ NUMBER OF YEARS _____

NUMBER OF CIGARS PER DAY: _____ NUMBER OF YEARS _____

NUMBER OF PIPES PER DAY: _____NUMBER OF YEARS _____

WHEN WAS YOURLAST CIGARETTE, CIGAR, PIPE? _____

DO YOU DRINK ALCOHOL ON A REGULAR BASIS? ☐ YES ☐ NO

IF NO, DID YOU DRINK HEAVILY IN THE PAST? ☐ YES ☐ NO

IF YES, HOW MUCH DO YOU TYPICALLY DRINK IN ONE WEEK? ____WHEN WAS YOUR LAST DRINK? _____

WHEN WAS YOUR LAST DRINK? _____

HAVE YOU EVER BEEN TREATED FOR SUBSTANCE ABUSE: ☐ YES ☐ NO

Have you ever had any of the following	Yes	No	Date of year	Place (Hospital or City)	Complications/Problems
EXAM BY A CARDIOLOGIST (HEART DOCTOR)					
HEART CATHERIZATION OR ANGIOGRAM					
CORONARY ANGIOPLASTY (PTCA/BALLOON/STENT)					
EXERCISE STRESS TEST(TREDMILL)					
ECHOCARDIOGRAM (ULTRASOUND OF THE HEART)					
PACEMAKER					

PREVIOUS OPERATIONS/PROCEDURES	YEAR	SURGEON	PLACE (HOSPITAL OR CITY)	COMPLICATIONS/PROBLEMS

REASONS FOR OTHER HOSPITALIZATIONS (NON-SURGICAL ADMISSIONS)	YEAR	PHYSICIAN	PLACE(HOSPITAL OR CITY)

PLEASE LIST ANY MEDICAL ILLNESSES , ANY HISTORY OF CANCER OR CHRONIC CONDITIONS	HOW LONG HAVE YOU HAD THIS

IF YOU ARE SCHEDULED FOR SURGERY OR A HOSPITAL STAY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

HAVE YOU OR ANY BLOOD RELATIVES HAD ANY PROBLEMS WITH ANESTHESIA? □ YES □NO

IF YES PLEASE DESCRIBE: _____

_____