



*Please complete this form before your appointment*

Date of Appointment \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

**ADVANCED DIRECTIVES:** Durable Power of Attorney (Will):  Yes  No  
 Healthcare Proxy (Living Will):  Yes  No

**ALLERGIES:**

Drugs and Reaction:					
Seafood or Shellfish	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Iodine/X-Ray Contrast	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

**SOCIAL HISTORY:**

Marital Status:  Married  Single  Divorced  Widowed  Other

Children:  Yes, Daughters (#) \_\_\_\_\_ Sons (#) \_\_\_\_\_  No

Employed:  Yes, Occupation \_\_\_\_\_  No  Retired  Disabled

Diet  Regular  Special \_\_\_\_\_

Exercise  Sedentary  Moderate  Vigorous

Tobacco Use  Never  Yes, please continue filling out next section:

❖ Tobacco Products Used  Cigarettes  Cigars  Pipe  Chewing  Vaping

How many per day \_\_\_\_\_ Number of Years Used \_\_\_\_\_

Age Started \_\_\_\_\_ Age Stopped \_\_\_\_\_

Year Quit \_\_\_\_\_

Alcohol Consumption  Yes  No If yes, type and amount \_\_\_\_\_

Street Drug Use  Yes  No

Caffeine Consumption  Yes  No If yes, type and amount \_\_\_\_\_

**FAMILY CARDIAC HISTORY:** *Please include cardiac/vascular history; heart attack, congenital heart problems, sudden death, arrhythmia, congestive heart failure, stroke, stents in legs or heart, pacemaker etc.*

Family history of Coronary Disease before 60 years old?  Yes  No Adopted?  Yes

Member	Living	Deceased	Age	History	Cause of Death
Father					
Mother					
Brother (s)					
Sister (s)					

**PAST MEDICAL HISTORY:**

Mark if you have ever had or currently have the following and the year:

✓ Year

✓ Year

**SURGICAL HISTORY:**

Diabetes			High Cholesterol		
Blood Clots			Hypertension		
Sleep Disorder			Heart Attack		
Tuberculosis			Stroke/TIA's		
Lung Disease			Rheumatic Fever		
Asthma			Thyroid Disease		
Heart Murmurs			Peripheral Vascular Disease		
Kidney Disease			Blood Transfusions		
Cancer			Hepatitis		
Other:					

Surgeries	Year

**CARDIAC HISTORY:**

Please list previous cardiac procedures (Stress test, Echocardiogram, Heart Catheterization, etc.)

- 1). \_\_\_\_\_ Year: \_\_\_\_\_
- 2). \_\_\_\_\_ Year: \_\_\_\_\_
- 3). \_\_\_\_\_ Year: \_\_\_\_\_
- 4). \_\_\_\_\_ Year: \_\_\_\_\_
- 5). \_\_\_\_\_ Year: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

*PLEASE CHECK ONLY WHAT IS A CURRENT OR ONGOING PROBLEM*

	✓		✓		✓
Weight Gain		Weight Loss		Fever	
Visual Changes		Hearing Loss			
Snoring		Coughing Up Blood		Short of Breath	
Nausea		Reflux		Bleeding	
Hematuria (Blood in Urine)		Night Time Urination			
Dizziness		Memory Loss		Seizures	
Depression		Hallucinations		Anxiety	
Acute Anemia		Low Platelets			
Female-History of Oral Contraceptives		Male-Erectile Dysfunction			
Goiter		Tremors			
Rash		Skin Sores			
Joint Pain		Muscle Aches			

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_