PATIENT HISTORY

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Patient Name ______________________________ Today's Date ______________

Do you smoke? Yes No If so, how much a week? ____________________
If you quit, how long ago? ____
Do you drink? Yes No If so, how much a week? ____________________

Have you ever been diagnosed with? (Put a Check)

High Blood Pressure _____
High Cholesterol _____
Abnormal EKG _____
Chest Pain / Angina _____
Palpitations _____
Coronary Artery Disease _____
Coronary Artery Bypass _____
Stents _____
Heart Attack _____
Stroke _____
Congestive Heart Failure _____

Shortness of Breath _____
COPD _____
Atrial Fibrillation _____
Sick Sinus Rhythm _____
Pacemaker _____
ICD (Defibrillator) _____
Peripheral Vascular Disease _____
Deep Vein Thrombosis _____
Dizzy Spells _____
Diabetes _____
GERD _____

Other ____

*If you have a pacemaker, ICD, or stents - please allow the secretary to copy your Card. **Remember to carry your card.*

Family History: (Mother, Father, Brother, Sister, or Child)

Hypertension _____
Coronary Artery Disease _____
Heart Attack _____

Hypercholestorolosis _____
Diabetes _____
Cancer _____

Mother's DOB ____________________ Deceased? Yes No
Father's DOB ____________________ Deceased? Yes No

Primary Care Physician ____

Pharmacy & Location ____