Patient Name: ______________________ **Date:** ____________

Date of Birth: ______________ **Age:** ________ **Sex: Male**________ **Female** ______

Primary Care Physician: ______________________

Referring Physician: ______________________

Reason for today's visit: ______________________

Medication	Dosage	Frequency (How Often)

Do you have any drug allergies? Yes No (If yes, please list below)

Medication Name: ______________ Reaction: ______________

Medication Name: ______________ Reaction: ______________

Medication Name: ______________ Reaction: ______________

Medication Name: ______________ Reaction: ______________

Have you received the Influenza vaccine? ☐ Yes, date ____________ ☐ No

Have you received the Pneumococcal vaccine? ☐ Yes, date ____________ ☐ No

NEW PATIENT INTAKE FORM

Cardiac Risk Factors

History of heart disease? Yes No

___ Heart attack Date/Facility ______________________________

___ Stents Date/Facility ______________________________

___ Bypass surgery Date/Facility ______________________________

History of stroke or mini stroke? Yes No Date ______________________________

History of peripheral circulation problems? Yes No

Do you have a history of high blood pressure? Yes No

Do you have a history of diabetes mellitus? Yes No

Have you ever been told you have high cholesterol? Yes No

Medical History

Have you had any of the following cardiac studies? If yes, please list the date and location of testing below.

Exercise Treadmill Stress Test: Date of most recent test______________ Facility ______________________________

Echocardiogram: Date of most recent test______________ Facility ______________________________

Nuclear Stress Test: Date of most recent test______________ Facility ______________________________

Any other diagnostic cardiology studies: Date of most recent test______________ Facility ______________________________

Please check only the medical problems that apply to you:

___ Congestive Heart Failure

___ Cardiomyopathy

___ Atrial Fibrillation/Atrial Flutter

___ Pacemaker/Defibrillator

___ Cardioversion/Ablation

___ Heart Valve Disorder

___ Mitral Valve Prolapse

___ Heart Valve Surgery

___ DVT (Deep vein thrombosis/blood clot in legs)

___ PE (Pulmonary embolism/blood clot in lungs)

___ COPD (Pulmonary disease)

___ OSA (sleep apnea) CPAP Machine: Y N

___ Thyroid Disorder

___ GERD (Gastric Reflux)

___ Gastric Ulcer

___ Stomach or intestine Bleeding

___ Hepatitis

___ Kidney Disease

___ Enlarged Prostate

___ Dementia

___ Arthritis

___ Depression

___ Anxiety

___ Anemia

___ HIV/AIDS

___ Cancer: ______________________________

____

___ Other: ______________________________

____

Surgical History

Surgery ________________________________ Date ________________

Surgery ________________________________ Date ________________

Surgery ________________________________ Date ________________

Surgery ________________________________ Date ________________

Surgery ________________________________ Date ________________

Surgery ________________________________ Date ________________

Family History

Does anyone in your family have a history of:

___ Heart disease (stents/heart attacks) Relationship/Age of diagnosis ________________

___ Heart surgery Relationship/Age of diagnosis ________________

___ Hypertension Relationship/Age of diagnosis ________________

___ Diabetes mellitus Relationship/Age of diagnosis ________________

___ Stroke Relationship/Age of diagnosis ________________

___ Vascular problems Relationship/Age of diagnosis ________________

Social History

___ Married ___ Single ___ Widowed ___ Children ___ Occupation ________________

Tobacco (including chewing tobacco/vapor/e-cigarrettes)

___ Current Age start/# of years __________ Amount per day __________

___ Former Age start/# of years __________ Amount per day __________

___ Never

Exercise ________________________ How often__________

Caffeine (coffee/teas/soft drinks) ______________ How much __________

Alcohol ______ Current ______ Former How much __________

Other substance use (including marijuana, cocaine,other illicit drugs) ________________