New Patient Health Status / History Survey

Personal Data

Last Name_____

First Name_____ Initial_____

Date of Birth_____

Marital Status: S M W D Gender: M F

Phone (_____) _____

Work Phone(_____) _____

Referring Physician/Internist_____

Family Physician_____

Employer_____

Allergies

❑ Iodine ❑ Shellfish

_____

Symptoms

❑ Ankle / feet swelling
❑ Bruising easily
❑ Chest pain / discomfort
❑ Cough (productive)_____with blood
❑ Dizziness / fainting
❑ Fever
❑ Leg cramping with exercise
❑ Palpitations
❑ Shortness of breath
❑ Weakness
❑ Weight Loss

Your Cardiac History

❑ Angioplasty date(s)_____
❑ Cardioversion date(s)_____
❑ Carotid Surgery date(s)_____
❑ Cardiac Catheterization date(s)_____
❑ Coronary bypass surgery date(s)_____
❑ Enlarged heart
❑ Heart attack date(s) _____
❑ Heart failure
❑ Heart murmur
❑ ICD date(s)_____
❑ Pacemaker date(s)_____
❑ Valve surgery date(s)

Family History

please check if your parent or sibling has ever had:

❑ Stroke
❑ Parent ❑ Siblings
❑ Diabetes
❑ Parent ❑ Siblings
❑ Heart Attack
❑ Parent ❑ Siblings
❑ High Blood Pressure
❑ Parent ❑ Siblings
❑ High Cholesterol
❑ Parent ❑ Siblings
❑ Coronary bypass surgery
❑ Parent ❑ Siblings

❑ Other_____

Your Personal Medical History

❑ Anemia
❑ Anxiety / Depression
❑ Arthritis
❑ Asthma
❑ Cancer date(s)_____
❑ Emphysema
❑ Hepatitis type _____
❑ Seizures
❑ Stroke date(s)_____
❑ Thyroid problem
❑ Tuberculosis
❑ Ulcer

Risk Factors

❑ Caffeine _____ drinks/day
❑ Alcohol consumption _____ drinks/week
❑ Diabetes _____ yrs.
❑ Exercise _____ times per week
type: _____
❑ High cholesterol
total _____ HDL _____ LDL
❑ High blood pressure _____ yrs.
❑ Low fat / low cholesterol diet
❑ Current Smoker _____yrs., _____ pks./day
❑ Past Smoker _____yrs.
_____ packs per day, _____ year quit

Patient Signature **Date**

Physician Signature **Date**