Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Today's date: _____ /_____ /_____

Primary Care Physician: _____ **Referring Physician:** _____

What is the reason for your visit today? _____

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following.
Mark all that apply. If none, mark, "**NO MEDICAL HISTORY**."

PAST	CURRENT		PAST	CURRENT	
○	○	Angina (Chest Pain)	○	○	Heart Valve Problem
○	○	Aortic Aneurysm	○	○	High Blood Pressure
○	○	Bleeding Tendencies	○	○	High Cholesterol
○	○	Blood Clot(s)		○	HIV Positive
○	○	Cancer	○	○	Hyperthyroid
○	○	Cardiomyopathy	○	○	Hypothyroid
○	○	Cirrhosis of Liver	○	○	Kidney Disease (Chronic)
○	○	COPD	○	○	Lupus
○	○	Coronary Artery Disease	○	○	Neck Artery Blockage
○	○	Diabetes (Type 1 Juvenile Onset)	○	○	Peripheral Artery Disease (PAD)
○	○	Diabetes (Type 2 Adult Onset)	○	○	Peripheral Vascular Disease (PVD)
○	○	Emphysema	○	○	Rheumatoid Arthritis
○	○	Epilepsy	○	○	Seizures
○	○	Esophageal Reflux	○	○	Sleep Apnea
○	○	Glaucoma	○	○	Stomach Ulcers
○	○	Heart Attack	○	○	Stroke
○	○	Heart Failure	○	○	Transient Ischemic Attack (TIA)
○	○	Heart Rhythm Problem	○	○	Tuberculosis
			○		**NO MEDICAL HISTORY**

Other Disease, Cancer or Significant Medical Illness (please specify):

_____

_____

DIAGNOSTIC TESTS

Please indicate when you last had each of the applicable tests:

	N/A	1 year or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10+ years ago	Were the results: Normal	Abnormal	Don't Know
Angiogram: Abdominal Aorta	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Angiogram: Coronary Arteries	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Angiogram: Legs / Arms	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Angiogram: Neck Arteries	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colonoscopy	○	○	○	○	○	○	○	○	○	○	○	○	○	○
EKG	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Mammogram	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pap / Pelvic Exam	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Rectal Exam	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stress test	○	○	○	○	○	○	○	○	○	○	○	○	○	○

***Attention Staff:** **All items in the diagnostic tests section need to be entered manually.**

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Patient History

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WOMEN

Please answer the following questions:

Are you currently pregnant?	yes ◯	no ◯	maybe ◯
Have you experienced menopausal symptoms (such as hot flashes)?	yes ◯	no ◯	maybe ◯
Have you gone through menopause?	yes ◯	no ◯	maybe ◯
Have you had any pregnancy complications?	yes ◯	no ◯	

SURGICAL HISTORY

Please mark all surgeries you have had:

- ◯ **I HAVE HAD NO SURGERIES**
- ◯ Appendectomy
- ◯ Cardiac Ablation
- ◯ Carotid Artery (Neck) Stent
- ◯ Carotid Artery (Neck) Surgery
- ◯ Colon Surgery
- ◯ Defibrillator
- ◯ Gallbladder Removal
- ◯ Heart Balloon / Stent
- ◯ Heart Bypass Surgery
- ◯ Heart Transplant
- ◯ Heart Valve Surgery
- ◯ Hysterectomy
- ◯ Leg Balloon / Stent
- ◯ Leg Bypass Surgery
- ◯ Lower Back Surgery
- ◯ Pacemaker
- ◯ Prostate Surgery
- ◯ Upper Back Surgery
- ◯ Varicose Vein Surgery
- ◯ Mastectomy — ◯ left ◯ right ◯ both

Other surgery, diagnostic procedure or hospitalization not mentioned above (please specify):

_____

_____

FAMILY MEDICAL HISTORY

◯ **Family History UNKNOWN** ◯ **ADOPTED** ◯ **NO SIGNIFICANT Family History**

Please indicate which family member(s) have had these illnesses:	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Anemia	◯	◯	◯	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯	◯	◯	◯
Bleeding Problems	◯	◯	◯	◯	◯	◯	◯	◯
Cancer (please specify type below)	◯	◯	◯	◯	◯	◯	◯	◯
Coronary Artery Disease (< age 50)	◯	◯	◯	◯	◯	◯	◯	◯
Coronary Artery Disease (> age 50)	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes (Type 2 Adult Onset)	◯	◯	◯	◯	◯	◯	◯	◯
Emphysema	◯	◯	◯	◯	◯	◯	◯	◯
Epilepsy	◯	◯	◯	◯	◯	◯	◯	◯
Heart Attack (MI – Acute)	◯	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯	◯
Heart Failure	◯	◯	◯	◯	◯	◯	◯	◯
Heart Rhythm Problem	◯	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯	◯	◯
High Cholesterol	◯	◯	◯	◯	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯	◯	◯	◯

Please specify the type of cancer (if applicable) and any other illnesses your family members have had:

_____

_____

Your Mother is: ◯ living — If living, age: _____

◯ deceased — If deceased, age at death: _____ Cause of death: _____

Your Father is: ◯ living — If living, age: _____

◯ deceased — If deceased, age at death: _____ Cause of death: _____

SOCIAL HISTORY

ALCOHOL USE

Do you now, or have you ever used alcohol?
never drank alcohol ◯
yes ◯
yes, in moderation (< 2 per day) ◯
recovering alcoholic ◯
stopped drinking alcohol ◯
If you no longer drink alcohol, when did you stop: _____

How many cans / bottles of beer per week?	0 ◯	1 - 7 ◯	8 - 14 ◯	15 - 21 ◯	22 + ◯
How many glasses of wine per week?	0 ◯	1 - 7 ◯	8 - 14 ◯	15 - 21 ◯	22 + ◯
How many drinks of liquor per week?	0 ◯	1 - 7 ◯	8 - 14 ◯	15 - 21 ◯	22 + ◯

CAFFEINE USE

Do you consume caffeine?	do not use caffeine ◯	yes, only occasionally ◯			yes, regularly ◯
How many cups of coffee per day?	0 ◯	1 ◯	2 ◯	3 ◯	4 + ◯
How many cups / glasses of tea per day?	0 ◯	1 ◯	2 ◯	3 ◯	4 + ◯
How many soft drinks per day?	0 ◯	1 ◯	2 ◯	3 ◯	4 + ◯

DRUG USE

Do you use illicit drugs? yes ◯ no ◯ in the past ◯

Which type(s):
amphetamines ◯ cocaine ◯ LSD / hallucinogens ◯
barbiturates ◯ heroin ◯ marijuana ◯

EDUCATION

Mark highest level:
NONE ◯ grades 1 - 6 ◯ grades 7 - 12 ◯ GED ◯ trade school ◯ graduate (13+) ◯ postgraduate (17+) ◯

EMPLOYMENT:

working full time ◯ working part time ◯ not currently employed ◯ currently on disability ◯ retired ◯

ETHNICITY:

Hispanic or Latino ◯ not Hispanic or Latino ◯ declined ◯ unknown ◯

RACE:

American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ White ◯ unknown ◯ declined ◯

LANGUAGE PREFERENCE:

English ◯ Spanish ◯ Vietnamese ◯ Korean ◯ other (please specify): ◯ _____

LEVEL OF PHYSICAL ACTIVITY:

sedentary ◯ heavy labor on job ◯ exercise inhibited by condition ◯ exercise regularly ◯ physical activity tolerance recently decreased ◯

LIVING ARRANGEMENTS:

independently alone ◯ independently with spouse ◯ residential institution ◯ with or caring for children ◯ with grandparent(s) ◯ with parent(s) ◯ with roommate(s) ◯

MARITAL STATUS:

married ◯ separated ◯ divorced ◯ widowed ◯ single ◯

DIET

Mark any specific nutritional plan or diet that you are on:
high fiber ◯ low cholesterol ◯ low fat ◯ low sugar ◯ vegetarian or vegan ◯ other (please specify): ◯ _____

TOBACCO USE

Smoking status:
current smoker (every day) ◯ current smoker (some days) ◯ former smoker ◯ never smoked ◯ smoker, current status unknown ◯ unknown if ever smoked ◯

Do you wish to stop smoking? yes ◯ no ◯

Packs per day (now or in the past): <1 ◯ 1 ◯ 1 – 1 ½ ◯ 1 ½ - 2 ◯ > 2 ◯

Years smoked (now or in the past):

less than 5	5	10	15	20	25	30	35	40+
◯	◯	◯	◯	◯	◯	◯	◯	◯

Do you use other tobacco products? no ◯ cigars ◯ pipe ◯ chewing tobacco / snuff ◯

If you smoke cigars or a pipe, how many per week?
occasionally ◯ 1 ◯ 2 - 7 ◯ 8 - 14 ◯ 15+ ◯

If you use chewing tobacco or snuff, how many cans per week?
occasionally ◯ <1 ◯ 1 ◯ 1 - 2 ◯ > 2 ◯

Are you exposed to passive (second hand) smoke? yes, outdoors only ◯ yes ◯ no ◯

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Patient History

Please answer every question.

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ALLERGIES

Please mark all allergies you have. Include your reactions. (e.g., hives, welts, rash, itching, nausea, etc.)

○ I HAVE NO KNOWN ALLERGIES

Substance:	Reaction:
○ Aspirin	
○ Dyes for X-Ray Tests	
○ Penicillin	
○ Sulfa	
○ Medication Allergy (please specify):	

Substance:	Reaction:
○ Dairy	
○ Eggs	
○ Latex	
○ Shellfish	
○ Food / Environmental Allergy (please specify):	

MEDICATIONS

Please list all medications you are currently taking or provide a list.
Include prescriptions, over-the-counter medications, vitamins and supplements.

○ I AM NOT TAKING ANY MEDICATIONS OR SUPPLEMENTS

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

PHARMACY

What is the primary pharmacy that you use? Name: _____ Location: _____

Do you use a mail order pharmacy? Name: _____ Location: _____

ADULT IMMUNIZATIONS

Please list all immunizations you have had:

Name of Immunization	Date
○ Flu	
○ Hepatitis B	
○ Pneumonia	
○ Tetanus	
○ MMR	
○ Zoster	

Name of Immunization	Date
○ Other (please specify):	