Name______________________________ Age_____ Primary Care Physician ________________________

Referring Physician __________________________ Other Physicians _____________________________

List Medications (Include Dose) **List Vitamins (Include Herbals)**

_______________________________ _____________________________
_______________________________ _____________________________
_______________________________ _____________________________
_______________________________ _____________________________
_______________________________ _____________________________

List Over the Counter Medicines

_______________________________ _____________________________
_______________________________ _____________________________

Allergies

____

Describe symptoms that brought you to the doctor

____

Family History

Mothers Age_____ Age Deceased_____ Cause of Death_____ Other Medical Problems _______________
Fathers Age_____ Age Deceased_____ Cause of Death_____ Other Medical Problems _______________
Brothers Age_____ Age Deceased____Cause of Death_____ Other Medical Problems ________________
Sisters Age _____ Age Deceased_____ Cause of Death_____ Other Medical Problems ________________

Social History (Circle Yes or No)

Smoke	Yes	No	How Much______	How Long _____
Past Smoker	Yes	No	How Much______	How Long _____
Alcohol	Yes	No	How Much______	How Long _____
Pets	Yes	No		

Occupation _______________________________ Retired When ___________________________________

Living Arrangements ____

Pharmacy **City** **Phone Number**

____
____

Past Medical History **(Circle all that apply to you)**

Heart Attack	Stroke/TIA	COPD
Thyroid Disease	Angina/ Chest Pain	Shortness of Breath
Hiatal Hernia	Anxiety	Arthritis
Asthma	Peptic Ulcer Disease	Bowel Problems
Heart Murmur	Emphysema	Prostate Disease
Congestive Heart Failure	Cancer	Anemia
Palpitations	Diabetes	Rheumatic Fever
Irregular Heart Beat	Circulation Problems	Scarlet Fever
High Blood Pressure	Kidney Disease	Liver Disease

Other ____

Surgeries (Please List)

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Please check procedures you have undergone

____Stress Test ____CT Scan ____ Echocardiogram ____Pet Scan

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