Upper Chesapeake Cardiology **New Patient**

Name _____ **Primary Care Physician** _____

Date _____ **Age** _____ **Date of Birth:** _____

E-Mail Address:_____

Why have you been referred to a cardiologist?

Have you ever seen a cardiologist before? (If yes, give details)

Do you have any of the following? (Check yes or no)

☐ Yes ☐ No A History of Smoking. If yes, how many packs per day ____; number of years ____

☐ Yes ☐ No High Blood Pressure

☐ Yes ☐ No High Cholesterol

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Peripheral Vascular Disease

For Women Only:

☐ Yes ☐ No Are you pregnant?

Name any drugs to which you are allergic:

_____

_____

_____

Please list all the medications you are currently taking:

Medications	Dose	Frequency (number of times per day)

Pharmacy/Mail Order: **Location/Phone Number:**

Have you ever had any of the following: (Check Yes or No) If yes, please describe

☐ Yes ☐ No a heart attack
☐ Yes ☐ No angina
☐ Yes ☐ No heart murmur
☐ Yes ☐ No rheumatic fever
☐ Yes ☐ No congestive heart failure or heart enlargement
☐ Yes ☐ No blue lips or fingernails
☐ Yes ☐ No a stress test
☐ Yes ☐ No an echocardiogram
☐ Yes ☐ No a heart catheterization or angioplasty
☐ Yes ☐ No heart, coronary or valve surgery
☐ Yes ☐ No a pacemaker or defibrillator

List the names and year of any **operations you have had** _____
_____
_____
_____

List the names of any **disease or serious injuries you have had which required hospitalization**_____
_____
_____
_____

List any **serious illnesses or injuries which you have had that DID NOT require hospitalization** _____
_____
_____
_____

Social History

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

Do you have children? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No
How much alcohol do you drink per week? _____
How much coffee, tea or sodas do you drink daily? Coffee _____ Tea _____ Sodas _____
What is your highest education level achieved? Education: ☐ Jr. High School ☐ High School/GED ☐ Vocational School ☐ College ☐ Other
Occupation: _____

Patient Name: _____ Date of Birth:_____

Family History

Has a family member ever had a heart attack, angina, heart failure or other heart problem?

☐ Yes ☐ No If yes, please describe:

_____

_____

_____

_____

_____

Have you ever had any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
Chest Pain	☐	☐	Excessive Sweating	☐	☐	Shortness of Breath-Lying Flat	☐	☐
Palpitations	☐	☐	Passing Out	☐	☐	Wake at Night w/Shortness of Breath	☐	☐
Leg Pain/ Claudication	☐	☐	Edema (Swelling)	☐	☐	Current Fever	☐	☐
Weight Gain	☐	☐	Weight Loss	☐	☐	Shortness of Breath – Exertional	☐	☐
Visual Changes	☐	☐	Hearing Loss	☐	☐	GI Bleeding	☐	☐
Snoring	☐	☐	Coughing up Blood	☐	☐	Seizures	☐	☐
Nausea	☐	☐	Reflux	☐	☐			
Blood in Urine	☐	☐	Urination at Night	☐	☐			
Dizziness	☐	☐	Memory Loss	☐	☐			
Depression	☐	☐	Hallucinations	☐	☐			
Acute Anemia	☐	☐	Low Platelets in Blood	☐	☐			
History of Hormonal Birth Control (Women)	☐	☐	Erectile Dysfunction (Men)	☐	☐			
Goiter	☐	☐	Tremors	☐	☐			
Current Rash	☐	☐	Current Skin Sores	☐	☐			
Joint Pain	☐	☐	Muscle Pain	☐	☐			