

Patient Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Height: _____ ft. _____ in. Weight: _____ lbs. Primary Care Physician: _____

Race (Please circle):

White | Black/African American | American Indian/Alaska Native | Asian | Native Hawaiian/other Pacific Insider | Other

Have you seen a cardiologist? Yes No If so, please list physician's name: _____

May we release information to your primary care physician? Yes No Consult requested by: _____

Reason for today's visit: _____

Was this the result of an accident? Yes No If so, please describe: _____

Was it work related? Yes No

Have you been treated previously for this condition? Yes No If so, please describe: _____

Date symptoms began: _____

CURRENT MEDICATIONS (Please include all prescription and over-the-counter medications):

Name / Dose / How Often	Name / Dose / How Often
1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____

Allergies? Yes No List them: _____

Do you have any metal allergies (e.g. nickel, etc.) Yes No List them: _____

Do you have a latex allergy? Yes No

PERSONAL AND SOCIAL HISTORY

Do you use tobacco? Yes No If so, what type and how much? _____

Do you drink alcohol? Yes No If so, how much and how frequently? _____

Do you regularly participate in sports or physical activity? Yes No If so, how much and how frequently? _____

FOR INTERNAL USE ONLY:

Physician's Signature: _____ Date: _____

MEDICAL AND SURGICAL HISTORY Previous Surgeries (please list most recent first):

Surgery	Year	Surgery	Year
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Have you had general anesthesia? Yes No Any problems? _____

PERSONAL MEDICAL HISTORY

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart attack | <input type="checkbox"/> Y <input type="checkbox"/> N DVT (blood clots) | <input type="checkbox"/> Y <input type="checkbox"/> N HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congestive heart failure | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease or hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Enlarged prostate |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atrial fibrillation | <input type="checkbox"/> Y <input type="checkbox"/> N STD (Type: _____) | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma |
| <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Hypothyroidism | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach ulcer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lung disease | <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Psoriasis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Depression | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoarthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Gout |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety | <input type="checkbox"/> Y <input type="checkbox"/> N Pneumonia | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer (Type: _____) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Neuropathy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy / Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N Claustrophobia | <input type="checkbox"/> Y <input type="checkbox"/> N Drug/alcohol dependency |
| <input type="checkbox"/> Y <input type="checkbox"/> N GERD | <input type="checkbox"/> Y <input type="checkbox"/> N Scoliosis | <input type="checkbox"/> Y <input type="checkbox"/> N Other: _____ |

Do you suffer from sleep apnea? Yes No If so, are you assisted by C-PAP? No Yes / Setting: _____

Do you have cardiac stents? Yes No

Do you have a pacemaker? Yes No If so, please specify: _____

Do you have a defibrillator? Yes No If so, please specify: _____

FAMILY HISTORY (Please check any that have occurred in any blood relatives):

- Y N Cancer (Type: _____) Y N Diabetes Y N Heart disease Y N Stroke
- Y N Bleeding tendencies Y N DVT (blood clots) Y N High blood pressure Y N Other: _____

REVIEW OF SYSTEMS Are you CURRENTLY experiencing any of these conditions / symptoms?**Constitutional**

- Y N Fever
 Y N Chills
 Y N Weight Loss

Cardiovascular

- Y N Chest pain
 Y N Irregular beat

Gastrointestinal

- Y N Abdominal pain
 Y N Reflux
 Y N Difficulty swallowing

Skin

- Y N Unusual bruises
 Y N Rashes

Musculoskeletal

- Y N Joint swelling
 Y N Joint pain

Neurologic

- Y N Numbness / Tingling
 Y N Migraines
 Y N Weakness

Genitourinary

- Y N Incontinence

Hematologic

- Y N Excessive bleeding

Respiratory

- Y N Shortness of breath

Psychiatric

- Y N Mental illness

Other

If you checked any of the above, are you receiving treatment? Yes No Please specify: _____

Patient's Name (Please Print): _____

Patient's Signature: _____ Date: _____