PENSACOLA CARDIOLOGY

Medical History

Patient Name: _____ DOB: _____ Sex: **M** or **F**

Phone #(s): _____ Email: _____

Reason for Visit: _____

_____

Pharmacy: _____ Phone #: _____

Preferred Lab: _____ Phone #: _____

Preferred Imaging Location: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Other Current Providers: _____

_____

Allergies / Adverse Reactions: _____

_____

Current Medications & Dosages: (Prescription, Herbs, or OTC) _____

_____

_____

Current or Recent Symptoms: _____

_____

_____

Family Medical History: If none, please check here: _____

Primary Relatives Only (Please indicate **M** for Mother, **F** for Father, **S** for Sister, **B** for Brother beside each condition.)

___ Angioplasty
___ Arrythmia
___ Congestive Heart Failure
___ Coronary Bypass Surgery
___ Coronary Stent / Balloon
___ Diabetes
___ Heart Attack
___ High Blood Pressure
___ High Cholesterol
___ Sudden Death
___ Stroke / TIA
___ Vascular Disease
Other:
_____
_____

Social History:

Occupation: _____ If retired, what did you do prior? _____

Marital Status: Single Married Divorced Widowed Number of Children: _____ Number of Grandchildren: _____
Diet: Regular Vegetarian Gluten Free Diabetic Carbohydrate Cardiac Other: _____
Do you exercise? None Occasionally Moderately Heavily

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Medical History (continued)

Patient Name: _____ Advanced Directive / Living Will: **Y** or **N**

Social History continued:

Are you a Current Tobacco User? **Y or N**. If so, how long? _____ If not, when did you quit? _____

What type(s) tobacco products? _____. How Much? _____

Do you drink Alcohol? **Y or N**. If so, how long? _____ If not, when did you quit? _____

What type(s) alcohol? _____. How Much? _____

Do you use any drugs? **Y or N**. If so, how long? _____ If not, when did you quit? _____

What type(s) of drugs? _____. How Much? _____

Do you intake Caffeine? **Y or N**. If so, how long? _____ If not, when did you quit? _____

What type(s) caffeine? _____. How Much? _____

Are you at risk for falls? If so, what type of aids do you use? _____

Do you feel safe in your home environment? _____

Past Surgeries & Hospitalizations: If none, please check here: _____

_____

_____

_____

Patient Past Medical History: (Please check the ones that apply.)

___ Anemia
___ Angioplasty or Stent
___ Aortic Aneurysm
___ Arrythmia
___ Arthritis
___ Asthma
___ Atrial Fibrillation
___ Atrial Flutter
___ Blood Clot
___ COPD
___ Cancer
___ Cardiomyopathy
___ Carotid Disease
___ Hyperlipidemia
___ Congenital Heart Disease
___ Congestive Heart Failure
___ Coronary Artery Disease
___ Deep Vein Thrombosis
___ Depression
___ Diabetes
___ Gerd/Reflux
___ Gastrointestinal Disease
___ Genitourinary Disease
___ Heart Attack
___ Heart Disease
___ Hematologic Disease
___ Hypertension
___ Kidney Disease
___ Liver Disease
___ Neurologic Disease
___ Pacemaker
___ Peripheral Artery Disease
___ Sleep Apnea
___ Sleep Disorder
___ Stroke / TIA
___ Thyroid Disease
___ Valvular Abnormalities
___ Valvular Heart Disease
___ Ventricular Arrythmia
___Warfarin /Coumadin Management
___ Abnormal Heart Monitor
Other:_____
_____
_____
_____
_____
_____

Is there any other information that you would like us to know to better care for your heart? _____

_____

_____

_____