



**PATIENT HISTORY FORM**

**INSTRUCTIONS:** Please assist us in providing a thorough evaluation of your medical condition by completing this form prior to your initial visit.

**NAME** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

**AGE** \_\_\_\_\_ **GENDER** \_\_\_\_\_

1. **REFERRAL INFORMATION:**  
Who referred you to this office? \_\_\_\_\_  
Family Physician: \_\_\_\_\_

2. **REASON FOR THIS EVALUATION (What specific questions do you want answered?):**  
\_\_\_\_\_  
\_\_\_\_\_

3. **DATE OF LAST COMPLETE PHYSICAL EXAMINATION WAS:** \_\_\_\_\_

4. <b><u>MEDICATIONS CURRENTLY USING:</u></b>	<b><u>DOSE:</u></b>	<b><u>DAILY FREQUENCY:</u></b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**\*\*\*PLEASE BRING IN SEPARATE LIST OF MEDICATIONS AND/OR PRESCRIPTION BOTTLES\*\*\***

5. <b><u>ALLERGIES OR DRUG INTOLERANCES:</u></b>	<b><u>REACTION EXPERIENCED:</u></b>
_____	_____
_____	_____

**\*\*\*PLEASE LIST ADDITIONAL ALLERGIES ON A SEPARATE PAGE\*\*\***

6. **SOCIAL HISTORY:**  
Place of Birth \_\_\_\_\_  
Past or Present Occupation \_\_\_\_\_

7. **SUBSTANCE USE:**  
**Caffeine Use (Coffee, Tea, Soda) – Please Circle One:**    Everyday       Occasional       Never  
How Much: \_\_\_\_\_    What Kind: \_\_\_\_\_  
**Alcohol Use – Please Circle One:**    Everyday       Occasional       Never  
How Much: \_\_\_\_\_    What type of Alcohol: \_\_\_\_\_  
Have you ever used Tobacco? Please Circle One:    Current       Former       Never  
**If Current User:** please circle all that apply to you:    Cigarette       Pipe       Cigar       Dip/Chew  
How much each day: \_\_\_\_\_    What age did you start: \_\_\_\_\_  
**If Former User:** Age Started: \_\_\_\_\_    Age Stopped: \_\_\_\_\_    How many packs/amount per day: \_\_\_\_\_

8. **ACTIVITY HISTORY:**  
What kind of exercise do you do?  
\_\_\_\_\_  
\_\_\_\_\_  
What is your main hindrance (if any) to exercising?  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

<b><u>✓ MEDICAL PROBLEM</u></b>	<b><u>DATE OF ONSET</u></b>	<b><u>DETAILS/CIRCLE ONE</u></b>
___ Abdominal Aneurysm	_____	_____
___ Anemia	_____	_____
___ Arthritis	_____	_____
___ Asthma	_____	_____
___ Atrial Fibrillation	_____	_____
___ Cancer (Please list type under Details)	_____	_____
___ Cardiomyopathy	_____	_____
___ Carotid Disease	_____	_____
___ Cellulitis	_____	_____
___ Cerebrovascular Accident (Stroke)	_____	_____
___ Chronic Dialysis	_____	Hemo or Peritoneal
___ Chronic Fatigue Syndrome	_____	_____
___ Chronic Obstructive Pulmonary Disease (COPD)	_____	_____
___ Coagulopathy (Bleeding Problems)	_____	_____
___ Colon Polyps	_____	_____
___ Congestive Heart Failure	_____	_____
___ Coronary Artery Disease	_____	_____
___ Deep Venous Thrombosis (DVT)	_____	_____
___ Dementia	_____	_____
___ Depression	_____	_____
___ Diabetes	_____	_____
___ Emphysema/COPD	_____	_____
___ Endocarditis	_____	_____
___ Gastrointestinal Bleed	_____	_____
___ Hepatitis	_____	_____
___ Hernia	_____	_____
___ HIV/AIDS	_____	_____
___ Hyperlipidemia (High Cholesterol)	_____	_____
___ Hypertension (High Blood Pressure)	_____	_____
___ Hyperthyroidism (High Thyroid)	_____	_____
___ Hypothyroidism (Low Thyroid)	_____	_____
___ Irritable Bowel	_____	_____
___ Kidney Stones (Chronic)	_____	_____
___ MRSA	_____	_____
___ Neuropathy	_____	_____
___ Palpitations	_____	_____
___ Peptic Ulcer Disease	_____	_____
___ Peripheral Vascular Disease (PVD)	_____	_____
___ Pneumonia	_____	_____
___ Pulmonary Embolus (Blood Clot to Lung)	_____	_____
___ Reflux/GERD	_____	_____
___ Renal Failure	_____	_____
___ Rheumatic Fever	_____	_____
___ Rheumatoid Arthritis	_____	_____
___ Seizure Disorder	_____	_____
___ Shortness of Breath	_____	_____
___ Sick Sinus Syndrome	_____	_____
___ Sleep Apnea	_____	_____
___ Supraventricular Tachycardia (SVT)	_____	_____
___ Syncope	_____	_____
___ Transient Ischemic Attack (TIA)	_____	_____
___ Tuberculosis	_____	_____
___ Ulcerative Colitis	_____	_____
___ Urinary Incontinence	_____	_____
___ Valvular Heart Disease	_____	_____
___ Ventricular Tachycardia	_____	_____
___ Wolf-Parkinson-White Syndrome	_____	_____

**PAST SURGICAL HISTORY**

<input checked="" type="checkbox"/> <b><u>SURGERY</u></b>	<b><u>DATE</u></b>	<b><u>DETAILS/CIRCLE ONE</u></b>		
		ENDOGRAFT	OPEN	
<input type="checkbox"/> Abdominal Aneurysm Repair	_____	_____	_____	_____
<input type="checkbox"/> Ablation (Please list type)	_____	_____	_____	_____
<input type="checkbox"/> Aortic Valve Replacement	_____	MECHANICAL	TISSUE	
<input type="checkbox"/> Appendectomy	_____	_____	_____	_____
<input type="checkbox"/> AV Fistula for Hemodialysis	_____	_____	_____	_____
<input type="checkbox"/> Automatic Implantable Cardioverter-Defibrillator (AICD)	_____	Manufacturer:	Serial #:	
<input type="checkbox"/> Back Surgery	_____	_____	_____	_____
<input type="checkbox"/> Bariatric Surgery (Weight Loss)	_____	_____	_____	_____
<input type="checkbox"/> Breast Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Cardiac Catheterization	_____	_____	_____	_____
<input type="checkbox"/> Cardioversion	_____	_____	_____	_____
<input type="checkbox"/> Carotid Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Cataract Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Cesarean Section (C-Section)	_____	_____	_____	_____
<input type="checkbox"/> Cholecystectomy (Gallbladder Removal)	_____	_____	_____	_____
<input type="checkbox"/> Colon Surgery	_____	_____	_____	_____
<input type="checkbox"/> Coronary Artery Bypass Graft (CABG)	_____	_____	_____	_____
<input type="checkbox"/> Defibrillator Battery Change-out	_____	Manufacturer:	Serial #:	
<input type="checkbox"/> Eye Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Foot Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Hemorrhoid Surgery	_____	INTERNAL	EXTERNAL	
<input type="checkbox"/> Hernia Repair	_____	_____	_____	_____
<input type="checkbox"/> Hip Surgery/Replacement	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Hysterectomy	_____	ABDOMINAL	VAGINAL	OVARIES
<input type="checkbox"/> Knee Surgery/Replacement	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Lung Resection	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Mastectomy	_____	_____	_____	_____
<input type="checkbox"/> Mitral Valve Repair/Replacement	_____	MECHANICAL	TISSUE	
<input type="checkbox"/> Pacemaker	_____	Manufacturer:	Serial #:	
<input type="checkbox"/> Pacemaker Battery Change-out	_____	_____	_____	_____
<input type="checkbox"/> Prostate Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Shoulder Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Stent; Coronary	_____	_____	_____	_____
<input type="checkbox"/> Stent; Vascular	_____	_____	_____	_____
<input type="checkbox"/> Thyroid Surgery	_____	_____	_____	_____
<input type="checkbox"/> Tonsillectomy	_____	_____	_____	_____
<input type="checkbox"/> Vascular Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Vein Surgery	_____	RIGHT	LEFT	BOTH
<input type="checkbox"/> Other:	_____	_____	_____	_____
<input type="checkbox"/> Other:	_____	_____	_____	_____

**FAMILY HISTORY**

<b><u>✓ MEDICAL PROBLEM</u></b>	<b><u>AGE DECEASED</u></b>	<b><u>FAMILY MEMBER(S)</u></b>
Abdominal Aortic Aneurysm (AAA)		
Alzheimer's Disease		
Anxiety		
Cancer (Please list type)		
Carotid Artery Disease		
Congestive Heart Failure (CHF)		
Dementia		
Depression		
Diabetes		
Heart Attack		
Heart Disease		
Heart Surgery		
Hyperlipidemia (High Cholesterol)		
Hypertension (High Blood Pressure)		
Peripheral Vascular Disease (PVD)		
Stroke		
Thyroid Disease		
Valvular Heart Disease		
Other:		