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NEW PATIENT HISTORY

1. NAME: (Last) _____ (First) _____ (MI)_____ Age _____
2. NAME OF REFERRING PHYSICIAN: _____
3. Weight _____ B.P. _____ P. _____ R. _____ D.O.B. __/__/__ Today's Date _____
4. REASON FOR VISIT TODAY: _____
5. DATE OF ONSET OF SYMPTOMS: _____
6. LIST ALL MEDICATIONS PATIENT IS CURRENTLY TAKING:

1._____ ____ MG _____ TIMES / DAY / WK 4._____ ____ MG _____ TIMES / DAY / WK
2._____ ____ MG _____ TIMES / DAY / WK 5._____ ____ MG _____ TIMES / DAY / WK
3._____ ____ MG _____ TIMES / DAY / WK 6._____ ____ MG _____ TIMES / DAY / WK

7. ALLERGIES (PLEASE LIST ALL): _____

_____

8. PAST MEDICAL HISTORY (CHECK ALL THAT APPLIES):

HYPERTENSION	_____	DATE _____	HIGH CHOLESTEROL	_____	DATE _____
HEART ATTACK	_____	DATE _____	IRREGULAR HEARTBEAT	_____	DATE _____
HEART MURMUR	_____	DATE _____	STROKE	_____	DATE _____
CARDIAC CATH	_____	DATE _____	DIABETES	_____	DATE _____
ANGIOPLASTY / STENT	_____	DATE _____	SWELLING OF LEGS/FEET	_____	DATE _____
POOR CIRCULATION	_____	DATE _____	THYROID PROBLEMS	_____	DATE _____
PACEMAKER	_____	DATE _____	ARTHRITIS	_____	DATE _____
ABNORMAL ECHO	_____	DATE _____	LIVER PROBLEMS	_____	DATE _____
HEART FAILURE	_____	DATE _____	STOMACH PROBLEMS	_____	DATE _____

9. PAST SURGICAL HISTORY:

_____ DATE _____ _____ DATE _____
_____ DATE _____ _____ DATE _____
_____ DATE _____ _____ DATE _____

10. RISK FACTORS:

CHOLESTEROL LEVEL _____ DATE CHECKED _____
TOBACCO USE _____ PKS OR CIGARETTES PER DAY X _____ YEARS
ALCOHOL USE _____ PER DAY / WEEK / MONTH X _____ YEARS
HISTORY OF HEART DISEASE IN PATIENT'S FAMILY (PLEASE LIST ALL) _____

_____

11. CONCLUSIONS:

ASSESSMENTS _____
PLAN _____ RETURN _____

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