

NAME: _____	AGE: _____	TODAY'S DATE: _____
WHAT PROBLEM(S) BRINGS YOU HERE TODAY?	WHO SENT YOU TO US? DOCTOR / OTHER _____ WHICH DOCTOR?	
WHAT SURGERY HAVE YOU HAD? <u>(LIST)</u> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____	HAVE YOU EVER HAD? DIABETES <u>YES</u> <u>NO</u> HEART PROBLEMS <u>YES</u> <u>NO</u> HEART ATTACK <u>YES</u> <u>NO</u> ANGINA IN PAST MONTH <u>YES</u> <u>NO</u> STROKE <u>YES</u> <u>NO</u> HIGH BLOOD PRESSURE <u>YES</u> <u>NO</u> CARDIAC CATHETERIZATION <u>YES</u> <u>NO</u> HIGH CHOLESTEROL <u>YES</u> <u>NO</u> HEPATITIS/HIV/AIDS (CIRCLE ONE) <u>YES</u> <u>NO</u> KIDNEY FAILURE <u>YES</u> <u>NO</u> CANCER <u>YES</u> <u>NO</u> ARE YOU PREGNANT <u>YES</u> <u>NO</u> BIRTH CONTROL <u>YES</u> <u>NO</u> PACEMAKER <u>YES</u> <u>NO</u> AUTOMATIC DEFIBRILLATOR <u>YES</u> <u>NO</u> OTHER SERIOUS DISEASES - LIST: _____ _____ _____	
WHY HAVE YOU BEEN HOSPITALIZED? (OTHER THAN SURGERY)		
LIST: 1. _____ 2. _____ 3. _____ 4. _____		
WHAT MEDICATIONS ARE YOU ALLERGIC TO? _____ _____	DO YOU TAKE A STATIN? <u>YES</u> <u>NO</u> DO YOU TAKE COUMADIN? <u>YES</u> <u>NO</u> DO YOU TAKE PREDNISONE? <u>YES</u> <u>NO</u> DO YOU TAKE ASPIRIN? <u>YES</u> <u>NO</u> DO YOU TAKE PLAVIX? <u>YES</u> <u>NO</u>	
NAMES & DOSE OF KNOWN MEDICATIONS: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	<i>LIST YOUR FAMILY MEDICAL PROBLEMS</i> FATHER: _____ MOTHER: _____ BROTHERS: _____ SISTERS: _____ SONS: _____ DAUGHTERS: _____	
	<i>PERSONAL HISTORY:</i> DO YOU SMOKE? <u>YES</u> <u>NO</u> HAVE YOU EVER SMOKED? <u>YES</u> <u>NO</u> WHEN DID YOU STOP? _____ HOW MUCH DO YOU DRINK? _____	
DOCTOR SIGNATURE:	PATIENT SIGNATURE:	
	DATED:	

DO YOU HAVE ANY OF THESE PROBLEMS?	(PLEASE CIRCLE)
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