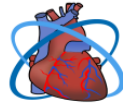


Name \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_



**Heart Consultants, LLC**

**PAST MEDICAL HISTORY:**

- Rheumatic Fever Scarlet Fever Heart Murmur High Blood Pressure  
Diabetes High/Bad Cholesterol Lung Disease/Asthma Emphysema/COPD Stroke Bleeding Problems  
Seizures Other \_\_\_\_\_ None of the Above  
Past Surgeries \_\_\_\_\_

- FAMILY HISTORY:** High Blood Pressure Diabetes High Cholesterol Coronary Artery Disease  
Heart Attack Angina Bypass Surgery Sudden Death Heart Failure Stroke Seizures  
Other \_\_\_\_\_ None of the Above

- SOCIAL HISTORY:** Married Single Divorced Widowed

Occupation: \_\_\_\_\_

**Do you do any of the following?**

1. Smoke: No Yes If so, how many packs per day?  
\_\_\_\_\_
2. Have you smoked in the past? No Yes If so, how many packs per day?  
\_\_\_\_\_
3. Drink Coffee/Soft drinks/Tea: No Yes If so, how many cups per day?  
\_\_\_\_\_
4. Have you in the past? No Yes If so, how many cups per day?  
\_\_\_\_\_
5. Drink Alcohol: No Yes if so, how much/how often?  
\_\_\_\_\_
6. Have you in the past? No Yes If so, how much/how often?  
\_\_\_\_\_
7. Use illegal street drugs: No Yes If so, what drug?  
\_\_\_\_\_
8. Have you used in the past? No Yes If so, what drug?  
\_\_\_\_\_
9. \_\_\_\_\_

**Check all that apply**

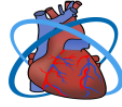
**REVIEW OF SYSTEMS:**

1. Hearing Loss Vision Changes Changes in Taste Changes in Smell None of the Above
2. Do you experience any of the following?Chills Fever Sweat Recent Weight Loss/Gain None
3. Cough Sputum Cough up blood Wheezing None
4. Vomiting blood Painful or difficulty swallowing Blood in stool  
Black tarry stool Chronic Diarrhea None
5. Urinary Problems Erectile Dysfunction Abnormal Periods Abnormal Bleeding None
6. Arthritis Rheumatism Spinal Disc Disease Painful Muscles Painful Joints None
7. Easy Bleeding Bruising None

Name \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_



**Heart Consultants, LLC**

8.  Burning/Cold hands and feet     Balance Problems     Chronic Headaches     Weakness     None
9.  Painful or Swollen Lymph Nodes     None
10.  Sores that do not heal properly     None
11.  Anxiety     Depression     None
12.  Sleep difficulty     Daytime Sleepiness     Sleep Apnea     Loud Snoring     None

Other: \_\_\_\_\_  
\_\_\_\_\_