



## NEW PATIENT DATABASE

Name:	DOB:	Visit Date:
Referring Physician:	Reason for Visit:	

**ALLERGIES?** \_\_\_\_\_

### **MEDICATIONS YOU ARE TAKING:**

Name	Dose	Frequency

### **Have you been experiencing any of the following symptoms?**

- |  |   |
|--|---|
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Leg / ankle swelling       |
| <input type="checkbox"/> Indigestion   | <input type="checkbox"/> More tired than usual      |
| <input type="checkbox"/> Arm pain  | <input type="checkbox"/> Feel sweaty or clammy      |
| <input type="checkbox"/> Neck / jaw pain                                       | <input type="checkbox"/> Pain in legs when you walk |
| <input type="checkbox"/> Shortness of breath                                   | <input type="checkbox"/> Dizzy                      |
| <input type="checkbox"/> Cough   | <input type="checkbox"/> Fainting                   |
| <input type="checkbox"/> Difficulty breathing when laying flat<br>On your back | <input type="checkbox"/> Palpitations               |
| <input type="checkbox"/> Waking up at night feeling short of breath            |   |

### **PAST MEDICAL HISTORY:** ( Please $\checkmark$ where appropriate )

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bypass operation           | <input type="checkbox"/> Sleep Apnea         |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Valve replacement          | <input type="checkbox"/> Kidney disease      |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Pacemaker                  | <input type="checkbox"/> Dialysis            |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Smoked Cigarettes          | <input type="checkbox"/> Lung disease        |
| <input type="checkbox"/> Angiogram           | <input type="checkbox"/> Stroke / TIA               | <input type="checkbox"/> Home oxygen         |
| <input type="checkbox"/> Angioplasty / stent | <input type="checkbox"/> Bleeding problems / ulcers | <input type="checkbox"/> Irregular Heartbeat |

### **FAMILY HISTORY:**

Has anyone in your family ever had a heart attack or “plugged vessels” at age 65 or less?

yes   no

### **SOCIAL HISTORY:**

Occupation:		
Alcohol Use:	Tobacco:	Drug: