

**PATIENT INFORMATION FORM**  
**(New Patient or New Consult for Prior Patient)**

*We thank you in advance for taking the time to complete this information. This will assist your physician in providing the best care for you.*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care/Family Physician: \_\_\_\_\_

What is the reason for today's visit? Please list any problems that you are experiencing.

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**Medications** (Please list the name, dose & how often or attach a current printed list if you have one)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Allergies** (Please list your allergies.)

\_\_\_\_\_

Are you allergic to X-ray dye? \_\_\_Yes \_\_\_No Please explain: \_\_\_\_\_

**Risk Factors**

- 1.) Do you smoke? \_\_\_Yes \_\_\_No
  - If yes, how many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_
  - If no, did you ever smoke regularly? \_\_\_\_\_ When did you stop? \_\_\_\_\_What other tobacco products do you use besides cigarettes? \_\_\_\_\_
  
- 2.) Do you have diabetes? \_\_\_Yes \_\_\_No  
If so, for how long? \_\_\_\_\_ Do you take medications for your diabetes? \_\_\_\_\_

3.) Have you ever been told that you have high blood pressure? \_\_\_Yes \_\_\_No  
If so, how long ago were you told? \_\_\_\_\_

4.) Do you have a family member (father, mother, brother, sister) that has had a heart attack, a stent, heart bypass surgery or a stroke? If so, who and at what age? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5.) Have you ever been told that you have high cholesterol? \_\_\_Yes \_\_\_No  
If so, has your high cholesterol ever required cholesterol medication? \_\_\_Yes \_\_\_No  
If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

 **“FOR FEMALES ONLY”**

- 1.) At what age did you have your last menstrual period? \_\_\_\_\_
- 2.) Have you ever taken hormone replacement therapy (estrogen)? \_\_\_Yes \_\_\_No  
If so, when and what type? \_\_\_\_\_
- 3.) Have you had a hysterectomy? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_

**Please check any items below that pertain to your cardiovascular history:**

- Heart attack (date: \_\_\_\_\_)
- Congestive heart failure (date: \_\_\_\_\_)
- Heart rhythm abnormalities
- Murmur
- Childhood heart defects
- Peripheral vascular disease
- Stroke (CVA) (date: \_\_\_\_\_)
- Transient ischemic attack (TIA) (date: \_\_\_\_\_)

**Please check any of the procedures below that you have had:**

| <b><u>Procedure</u></b>                             | <b><u>Date (if known)</u></b> | <b><u>Procedure</u></b>  | <b><u>Date (if known)</u></b> |
|---|-------------------------------|--|-------------------------------|
| <input type="checkbox"/> 1) Heart catheterization   | _____                         | <input type="checkbox"/> 7) Stents in vessels other than the heart | _____                         |
| <input type="checkbox"/> 2) Balloon/stent of heart  | _____                         | <input type="checkbox"/> 8) Pacemaker                              | _____                         |
| <input type="checkbox"/> 3) Heart bypass surgery    | _____                         | <input type="checkbox"/> 9) Internal defibrillator (ICD)           | _____                         |
| <input type="checkbox"/> 4) Heart valve surgery     | _____                         | <input type="checkbox"/> 10) EP (electrophysiologic study)         | _____                         |
| <input type="checkbox"/> 5) Carotid artery surgery  | _____                         | <input type="checkbox"/> 11) Colonoscopy                           | _____                         |
| <input type="checkbox"/> 6) Leg vein bypass surgery | _____                         |  |                               |

**Please complete the following information regarding your general medical/surgical history.**

**Check items below that pertain to you:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Bleeding disorder       | <input type="checkbox"/> Blood clots            | <input type="checkbox"/> History of blood transfusions |
| <input type="checkbox"/> Bowel disorders         | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Emphysema/COPD                |
| <input type="checkbox"/> Esophageal reflux(GERD) | <input type="checkbox"/> Gallbladder disease    | <input type="checkbox"/> Glaucoma/cataracts            |
| <input type="checkbox"/> Gout                    | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Hormone replacement           |
| <input type="checkbox"/> Kidney disease/stones   | <input type="checkbox"/> Liver disease/jaundice | <input type="checkbox"/> Lung disease                  |
| <input type="checkbox"/> Migraines               | <input type="checkbox"/> Pancreatic disease     | <input type="checkbox"/> Pneumonia                     |
| <input type="checkbox"/> Prostate problems       | <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Sleep apnea             | <input type="checkbox"/> Stomach/colon cancer   | <input type="checkbox"/> Thyroid problems              |
| <input type="checkbox"/> Tuberculosis (TB)       | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Vein problems/stripping       |

Other: (Please explain): \_\_\_\_\_

\_\_\_\_\_

**Please list any surgeries, tests or illnesses not mentioned on prior page:**

| <b><u>Significant surgery/illness/injuries</u></b> | <b><u>Year</u></b> |
|--|--------------------|
| _____  | _____              |
| _____  | _____              |
| _____  | _____              |
| _____  | _____              |
| _____  | _____              |

**Social History**

- 1.) What is your occupation? \_\_\_\_\_
- 2.) What is your marital status? \_\_\_\_\_
- 3.) How many children do you have? \_\_\_\_\_
- 4.) Do you exercise? \_\_\_Yes \_\_\_No  
If so, how often? \_\_\_\_\_
- 5.) Are you on a special diet? \_\_\_Yes \_\_\_No  
If so, please describe: \_\_\_\_\_
- 6.) Do you use caffeine? \_\_\_Yes \_\_\_No  
If so, how much? \_\_\_\_\_
- 7.) Do you drink alcoholic beverages? \_\_\_Yes \_\_\_No  
If so, how much? \_\_\_\_\_
- 8.) Do you use recreational street drugs? \_\_\_Yes \_\_\_No  
If so, please explain: \_\_\_\_\_



*Patients: Please do not fill out this page. Your physician/staff will complete this page.*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

History of Present Illness: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PE: Temp: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Reg/Irreg Resp: \_\_\_\_\_

Waist circumference: \_\_\_\_\_

Blood Pressure: L: \_\_\_\_\_ R: \_\_\_\_\_

Normal

Neck:

CV:

Lungs:

Abdomen:

Ext:  No edema  1+  2+

|       | Brachial | Radial | Femoral                        | Popliteal | DP | PT |
|-------|----------|--------|--------------------------------|-----------|----|----|
| Right |          |        | <input type="checkbox"/> Bruit |           |    |    |
| Left  |          |        | <input type="checkbox"/> Bruit |           |    |    |

Plan: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date: 02/27/06