

**NEW PATIENT PROFILE & MEDICAL HISTORY**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **MRN:** \_\_\_\_\_

**FAMILY HISTORY:**

- Diabetes
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Stroke

**PERSONAL HISTORY:**

- AIDS/HIV
- Asthma
- Cancer
- Congestive Heart Failure
- Diabetes
- Emphysema/COPD (lung Disease)
- Gout
- Heart Attack – If yes, when? \_\_\_\_\_
- Heart Murmur
- Hiatal Hernia/Reflux
- High Blood Pressure  
If yes, how is it treated? \_\_\_\_\_
- High Cholesterol or Triglycerides  
If yes, how is it treated? \_\_\_\_\_
- Irregular Heart Beats
- Kidney/Urinary Problems
- Mitral Valve Prolapse
- Peripheral Vascular Disease
- Rheumatic Fever
- Seizures
- Stroke – If yes, when? \_\_\_\_\_
- Thyroid Disorder
- Ulcers

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

- Bruise or Bleed Easily
- Cough
- Chest Pain/Pressure/Discomfort
- Dizziness
- Edema (Swollen legs, ankle or feet)
- Fatigue
- Heartburn
- Irregular Heart Beats or Palpitations
- Leg Pain when Walking
- Nausea/Vomiting/Abdominal Discomfort
- Shortness of Breath
- Sleep Disorder

**Have you had any of the following procedures? If so, when/where?**

- Angioplasty/Stent \_\_\_\_\_
- Heart/Blood Vessel Surgery \_\_\_\_\_
- Heart Catheterization \_\_\_\_\_
- Heart Valve Replacement \_\_\_\_\_
- Pacemaker/ICD \_\_\_\_\_
- Treadmill/Exercise Test \_\_\_\_\_
- Echocardiogram \_\_\_\_\_

**SOCIAL HISTORY:**

- Smoking  
If yes, how many per day? \_\_\_\_\_  
If you quit, when? \_\_\_\_\_
- Alcoholic Beverages  
If yes, how much per day? \_\_\_\_\_
- Caffeinated Beverages  
If yes, how much per day? \_\_\_\_\_
- Exercise  
If yes, how often and what type? \_\_\_\_\_

**WOMEN ONLY:**

- Do you take oral contraceptives?  N  Y
- Are you pregnant?  N  Y
- Planning to become pregnant?  N  Y
- Post-Menopausal?  N  Y
- Hysterectomy?  N  Y—When? \_\_\_\_\_

**MEN ONLY:**

- Prostate Problems?  N  Y
- Are you allergic to any medications?  
 No  Yes – If yes, please list below:  
\_\_\_\_\_  
\_\_\_\_\_

Please list the hospital name/dates where you have been hospitalized in the past year:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any recent procedures/surgeries:  
\_\_\_\_\_  
\_\_\_\_\_

Completed By: \_\_\_\_\_

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