FREEDMAN MEMORIAL CARDIOLOGY

PATIENT NAME:_____ DATE_____

DOB:_____ AGE:_____ PHARMACY:_____

PRIMARY MD:_____

NAME OF ALL OTHER DOCTORS YOU SEE:_____

FAMILY:

- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Diabetic
- ❑ Sudden Death
- ❑ Elevated Cholesterol
- ❑ Strokes
- ❑ Heart Failure
- ❑ Abdominal Aneurysm

YOUR MEDICAL HISTORY:

- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Diabetic
- ❑ Elevated Cholesterol
- ❑ Arthritis
- ❑ COPD
- ❑ Kidney Disease
- ❑ Cancer (If yes, where/when) _____
- ❑ Asthma
- ❑ Any other problems, please list:_____

SOCIAL HISTORY: ARE YOU PRESENTLY DOING? (YES/NO)
DO YOU HAVE A HISTORY OF? (LAST USED)

Tobacco Use _____
Alcohol_____
Drugs_____
Exercise *(Daily, Weekly, Occasionally)* _____
How many minutes?_____
Occupation / Work_____

LIST ALL MEDICATIONS AND DOSE:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES OR MEDICATION YOU CAN'T TAKE: _____
_____

YOUR SURGICAL HISTORY:
(List date and doctor that did your surgery, if known)

1) _____
2) _____
3) _____
4) _____
5) _____

ARE YOU HAVING ANY OF THE FOLLOWING? *(Explain how it makes you feel)*

- ❑ Chest Pain_____
- ❑ Short of Breath_____
- ❑ Fatigue / Tired _____
- ❑ Does your heart skip? _____
- ❑ Are you dizzy?_____
- ❑ Have you passed out?_____
- ❑ Do you have swelling?_____
- ❑ Do you have pain in your legs?_____