FREEDMAN MEMORIAL CARDIOLOGY

DO YOU HAVE A HISTORY OF? (LAST USED) Tobacco Use High Blood Pressure	PATIENT NAME:			DATE	
NAME OF ALL OTHER DOCTORS YOU SEE: FAMILY: SOCIAL HISTORY: ARE YOU PRESENTLY DOING? (YES DO YOU HAVE A HISTORY OF? (LAST USED)) Tobacco Use Heart Disease High Blood Pressure Diabetic Strokes Heart Failure Abdominal Aneurysm LIST ALL MEDICATIONS AND DOSE: YOUR MEDICAL HISTORY: Heart Disease High Blood Pressure Diabetic Elevated Cholesterol Arthritis Carpet (Figs., where/when) Asthma Any other problems, please list: LLERGIES OR MEDICATION YOU CAN'T TAKE: DUR SURGICAL HISTORY: EYOU HAVING ANY OF THE FOLLOWING? (Explain how it makes you feel) Chest Pain Short of Breath Fatigue / Tired Doses your heart skip? Are you dizzy? Have you passed out? Do you have swelling?	DOB:	AGE:	PHARMACY:		
FAMILY: Heart Disease High Blood Pressure Alcohol	PRIMARY MD:				
DO YOU HAVE A HISTORY OF? (LAST USED) Tobacco Use Heart Disease	NAME OF ALL OTHER	DOCTORS YOU SEE:			
Heart Disease	FAMILY:			SOCIAL HISTORY: ARE YOU PRESENTLY DOING? (YES/NO)	
High Blood Pressure	☐ Heart Disease				
□ Diabetic □ Sudden Death □ Exercise (Daily, Weekly, Occasionally) □ Elevated Cholesterol □ How many minutes? □ Occupation / Work □ Heart Failure □ Abdominal Aneurysm □ LIST ALL MEDICATIONS AND DOSE: 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: □ Carlorer (if yes, where/when) □ Asthma □ Any other problems, please list: □ CURS SURGICAL HISTORY: st date and doctor that did your surgery, if known) 1 □ Chest Pain □ Chest Pain □ Chest Pain □ Short of Breath □ Fatigue / Tired □ Does your heart skip? □ Are you dizzy? □ Are you dizzy? □ Are you dizzy? □ Are you dizzy? □ Do you have swelling? □ Do you have swellin		sure			
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