Meritas Health Cardiology

New Patient Information Form

Appointment Date: ______________________________

Name: ______________________________________ Date of Birth: ___________________ Phone #: ________________

Emergency Contact: _________________________________Phone #: ____________________Relationship:___________

Referring/Primary Care Physician: ____

HISTORY: Chief complaint: (describe major symptoms or problems that bring you to the clinic today)

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Have you previously seen a Cardiologist? If so, Who? ____________________ Where? ___________________________

Please mark any symptoms you are having now or have had recently:

Chest Pain: Yes or No	**Shortness of Breath:** Yes or No
☐ With exertion (while walking, climbing stairs, etc.) ☐ At rest (with emotional upset, stress) ☐ Awakens you from sleep	☐ With exertion (while walking, climbing stairs, etc.) ☐ At rest (with emotional upset, stress) ☐ Awakens you from sleep or difficulty breathing when lying flat.
Other Cardiac Symptoms: ☐ Palpitations (fluttering or skipped beats) ☐ Syncope (nearly fainting or fainting) ☐ Edema (Swelling in your hands, legs, ankles or feet)	**Sleep Apnea:** Yes or No ☐ CPAP ☐ BIPAP ☐ Loud Snoring ☐ Daytime tiredness, fatigue, drowsiness or sleepiness ☐ Someone has observed you stop breathing during sleep

PAST MEDICAL HISTORY:

Cardiovascular/Heart:	**Heart Procedures or Surgery:**	**Heart Procedures or Surgery cont:**
☐ Heart Attack ☐ Coronary Artery Disease ☐ Coronary Spasm ☐ Heart Murmur/Valve Problems Details: _________________________ ☐ Heart Rhythm Problems: (Bradycardia, Tachycardia, Atrial Fibrillation, Atrial Flutter, PSVT, SVT or Ventricular Tachycardia) Details: _________________________ ☐ TIA or Stroke ☐ Hypertension/High Blood Pressure ☐ High Cholesterol ☐ High Triglycerides	☐ Cardiac Catheterization When:______________________ Where:______________________ ☐ Cardiac Angioplasty or Stent(s) When:______________________ Where:______________________ ☐ CABG/Bypass Surgery How many vessels:___________ When:______________________ Where:_____________________ ☐ Heart Valve Replacement Which valve(s): ______________ When:______________________ Where:_____________________	☐ Pacemaker or Defibrillator ☐ Cardiac Ablation for: Atrial Fibrillation, Atrial Flutter, SVT or Ventricular Tachycardia When:_________________________ Where:________________________ **Peripheral Vascular Disease:** ☐ Arms ☐ Legs Surgery(s) or Stent(s) When:_________________________ Where:________________________ ☐ Carotid Artery Disease Surgery(s) or Stent(s) When:_________________________ Where:________________________

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PAST SURGICAL HISTORY: (Please list any surgeries you have had and when):

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PAST SERIOUS INJURIES: (Please list any serious injuries you have sustained i.e. broken bones, head injury etc.)

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FAMILY HISTORY:

	Living?	Age or Age at death	Health Problems or Cause of Death
Father	Yes or No	__________	______________________________
Mother	Yes or No	__________	______________________________
Spouse	Yes or No	__________	______________________________
Brothers	# Living	__________	______________________________
	# Deceased	__________	______________________________
Sisters	# Living	__________	______________________________
	# Deceased	__________	______________________________
Children	# Living	__________	______________________________
	# Deceased	__________	______________________________

SOCIAL HISTORY:

Marital Status: SINGLE MARRIED DOMESTIC PARTNER WIDOWED DIVORCED

Occupation (if retired use former occupation): ______________________________

Are you a Veteran: Yes or No

Do you currently or have you in the past used any form of tobacco products? Yes or No

If currently using, which form(s): ☐ Cigarettes, ☐ Cigars, ☐ Chewing Tobacco, ☐ Pipe

How often: ______________________________

If you have used tobacco in the past what form: ______________ How much daily: __________

Do you drink alcoholic beverages: Yes or No

If yes, what type and how frequently: ______________________________

Do you use recreational drugs? Yes or No

If yes, what kind, how often and when did you last use? ______________________________

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Medication	Dosage	How many times per day
______________________________	______________________	__________________________
______________________________	______________________	__________________________
______________________________	______________________	__________________________
______________________________	______________________	__________________________
______________________________	______________________	__________________________
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______________________________	______________________	__________________________
______________________________	______________________	__________________________
______________________________	______________________	__________________________
______________________________	______________________	__________________________

Allergies: (have you had allergies or sensitivities to medications or other substances in the past?) Please list below:

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Yes or No Have you had a reaction to iodine or an IV contrast used for CT or Cardiac Catheterization?

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Constitutional:	**Musculoskeletal:**	**Endocrine:**	**Genitourinary:**
☐ Recent change in weight Increase # of pounds ____ Decrease # of pounds____ ☐ Loss of Appetite ☐ Fever/Chills/Sweats ☐ Fatigue	☐ Muscle Cramps/Pain ☐ Joint Stiffness/Swelling ☐ Muscle Weakness ☐ Arthritis ☐ Gout ☐ Back Problems ☐ Limitation of Movement	☐ Diabetes ☐ Type 1 ☐ Type 2 ☐ Thyroid Problems ☐ Excessive Thirst ☐ Excessive Urination	☐ Urinary Frequency ☐ Blood in Urine ☐ Impotence ☐ Kidney Disease ☐ Kidney Stones ☐ Urinary Infections
Neurological: ☐ Dizziness ☐ Numbness/Tingling ☐ Paralysis ☐ Loss of Memory ☐ Headaches ☐ History of Head Injury ☐ Difficulty with Balance	**Ears/Nose/Throat/Mouth:** ☐ Hearing Loss ☐ Aids ☐ Nose Bleeds ☐ Sinus Infections ☐ Hoarseness ☐ Bleeding Gums ☐ Difficulty with Teeth ☐ Dentures	**Eyes:** ☐ Difficulty with Vision ☐ Glasses/Contacts ☐ Glaucoma ☐ Eye Injury	**Respiratory:** ☐ Asthma ☐ COPD/Emphysema ☐ Cough ☐ Wheezing ☐ Bronchitis ☐ Coughing up Blood ☐ PE (Pulmonary Embolus) ☐ Tuberculosis (TB)
Skin: ☐ Rashes ☐ Itching ☐ Hives ☐ Bruising Easily ☐ Lumps/Lesions ☐ Skin cancer	**Gastrointestinal:** ☐ Stomach Ulcers ☐ Abdominal Pain ☐ Colitis ☐ Black or Tarry Stools	**Other:** ☐ Bleeding Disorder Type: _______________ ☐ Clotting Disorder Type: _______________ ☐ Blood Clots ☐ DVT (deep vein thrombosis)	**Other:** ☐ Cancer Type: _______________ ☐ Liver Disease ☐ Varicose Veins ☐ Anxiety ☐ Depression

Physician Signature ____ Date _________________________