HEARTPLACE PATIENT HISTORY

Date:_____ Patient Name:_____

Physician Who Referred You:_____

Why are you here today/symptoms?_____

List all medications you are currently taking:

_____mg _____mg

_____mg _____mg

_____mg _____mg

Are you allergic to any medications?_____

Past Medical History: "Check all appropriate boxes."

	Yes	No	Date		Yes	No	Date
Diabetes	___	___	_____	Echocardiogram	___	___	_____
Hypertension	___	___	_____	Cardiac CATH	___	___	_____
Stroke	___	___	_____	Balloon Angiography	___	___	_____
Heart Attack	___	___	_____	Heart Surgery	___	___	_____
Heart Murmur	___	___	_____	ECG	___	___	_____
Irregular Heartbeat	___	___	_____	Pacemaker	___	___	_____
HBV/HIV/TB	___	___	_____	Palpitations	___	___	_____
Leg Cramps	___	___	_____	Swelling	___	___	_____

Problems with:				**List Operations:**	**Date:**
Thyroid	___	___	_____	1._____	_____
Stomach	___	___	_____	2._____	_____
Gallbladder	___	___	_____	3._____	_____
Liver	___	___	_____	4._____	_____
Pancreas	___	___	_____	5._____	_____
Arthritis	___	___	_____	6._____	_____

1) Do you have any concerns or problems not listed above?_____

_____

2) Have you had your cholesterol checked? Y/N What was it?_____
3) Do you smoke?_____Packs per day?_____How Long?_____
4) Family History:

_____

_____