Huntsville Cardiovascular Clinic, P.C.

PATIENT INFORMATION

*** To be filled out as a new patient and once every 6 months. ***

Patient Name:_____ **Date of Birth:**_____ **Age:**_____

Referring MD:_____ **Family MD:**_____

Have you recently been seen at a hospital or in the ER? Yes_____ No_____ If yes, which one and why?

_____

Why are you here today? _____

Allergies: _____

_____

Medications (Please include dosages, prescriptions, over-the-counter, vitamins and supplements)

1._____ 16._____
2._____ 17._____
3._____ 18._____
4._____ 19._____
5._____ 20._____
6._____ 21._____
7._____ 22._____
8._____ 23._____
9._____ 24._____
10._____ 25._____
11._____ 26._____
12._____ 27._____
13._____ 28._____
14._____ 29._____
15._____ 30._____

Surgeries / Procedures (Please include dates)

1._____
2._____
3._____
4._____
5._____
6._____
7._____

Please See Back Page

Patient/Family History

Please indicate (by circling) whether you or the listed family members have or have had the following conditions

Asthma	Self	Mother	Father	Brother	Sister	Grandparent
Atrial Fibrillation	Self	Mother	Father	Brother	Sister	Grandparent
Bleeding Disorder	Self	Mother	Father	Brother	Sister	Grandparent
Blood Clots	Self	Mother	Father	Brother	Sister	Grandparent
Carotid Artery Disease	Self	Mother	Father	Brother	Sister	Grandparent
Congestive Heart Failure	Self	Mother	Father	Brother	Sister	Grandparent
Diabetes	Self	Mother	Father	Brother	Sister	Grandparent
Edema or Swelling	Self	Mother	Father	Brother	Sister	Grandparent
Heart Attack	Self	Mother	Father	Brother	Sister	Grandparent
Heart Blockage	Self	Mother	Father	Brother	Sister	Grandparent
Hypertension	Self	Mother	Father	Brother	Sister	Grandparent
High Cholesterol	Self	Mother	Father	Brother	Sister	Grandparent
Leg Pain	Self	Mother	Father	Brother	Sister	Grandparent
Migraines	Self	Mother	Father	Brother	Sister	Grandparent
Palpitations	Self	Mother	Father	Brother	Sister	Grandparent
Peripheral Vascular Disease	Self	Mother	Father	Brother	Sister	Grandparent
Rhythm Problems	Self	Mother	Father	Brother	Sister	Grandparent
Shortness of Breath	Self	Mother	Father	Brother	Sister	Grandparent
Sleep Apnea	Self	Mother	Father	Brother	Sister	Grandparent
Stroke/TIA	Self	Mother	Father	Brother	Sister	Grandparent
Thyroid Problems	Self	Mother	Father	Brother	Sister	Grandparent
Valve Problems	Self	Mother	Father	Brother	Sister	Grandparent
Varicose Veins	Self	Mother	Father	Brother	Sister	Grandparent

Personal Information

Do you use tobacco? Yes No If yes, how much and for how long? _____

If you used to smoke, when did you quit?_____ How much did you smoke?_____

How long did you smoke before quitting? _____

Do you drink alcohol? Yes No If yes, how much and how often? _____

Do you drink caffeine? Yes No If yes, what and how much? _____

Are you employed? Yes No If yes, what do you do?_____

Are you married? Yes No Do you live alone? Yes No

How often do you exercise?_____

What pharmacy do you use?_____