

---

## Forms\_Cardiology

---

### PATIENT INFORMATION - PLEASE PRINT

#### FULL LEGAL NAME(FIRST NAME)

first name	<input type="text"/>	middle name	<input type="text"/>	last name	<input type="text"/>	nick name	<input type="text"/>		
street address number	<input type="text"/>	street name	<input type="text"/>	street name apt	<input type="text"/>	street name space	<input type="text"/>		
po box address number	<input type="text"/>	po box street	<input type="text"/>	po box apt	<input type="text"/>	po box space	<input type="text"/>		
city	<input type="text"/>	state	<input type="text"/>	zip code	<input type="text"/>	social security	<input type="text"/>		
home phone	<input type="text"/>	cell phone	<input type="text"/>						
email address	<input type="text"/>								
<input type="text"/> [IMAGE]	age	<input type="text"/>	sex	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	marital status	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	occupation	<input type="text"/>	
employer name	<input type="text"/>	employer street address	<input type="text"/>	employer city	<input type="text"/>	employer state	<input type="text"/>	employer zip code	<input type="text"/>
business phone	<input type="text"/>	extension	<input type="text"/>	drivers license	<input type="text"/>	drivers license state	<input type="text"/>		

## SPOUSE'S, PARENT'S, AND / OR GUARANTER'S INFORMATION

spg refers to spouse/parents/guarantors

spg first name	<input type="text"/>	spg middle name	<input type="text"/>	spg last name	<input type="text"/>	spg occupation	<input type="text"/>
spg address if different than above	<input type="text"/>	spg city	<input type="text"/>	spg state	<input type="text"/>	spg zip code	<input type="text"/>
spg employer street address	<input type="text"/>	spg employer city	<input type="text"/>	spg employer state	<input type="text"/>	spg employer zip code	<input type="text"/>
						spg employer business phone	<input type="text"/>
						spg employer extension	<input type="text"/>

## CONCERNING INSURANCE

concerning insurance details

☐ SPOUSE IS POLICY HOLDER ☐ MEDICARE ☐ MEDICAL ☐ HMO ☐ WORK COMP

primary insurance co here	<input type="text"/>	primary insurance group number	<input type="text"/>	primary insurance id number	<input type="text"/>
primary insurance insured name	<input type="text"/>	<input type="text"/>		primary insurance insured address	<input type="text"/>
		[IMAGE]			
secondary insurance co name	<input type="text"/>	secondary insurance group number	<input type="text"/>	secondary insurance id number	<input type="text"/>
secondary insurance insureds name	<input type="text"/>	<input type="text"/>		secondary insurance insureds col address	<input type="text"/>
		[IMAGE]			

## EMERGENCY INFORMATION

person to notify in case of emergency not leaving with you	<input type="text"/>	relationship	<input type="text"/>
person address	<input type="text"/>	person street	<input type="text"/>
		person apt	<input type="text"/>
person city	<input type="text"/>	person state	<input type="text"/>
		person zip code	<input type="text"/>
		person home phone	<input type="text"/>

## History and Physical



Medicine  
detail2


Medicine  
detail3


Medicine  
detail4


Medicine  
detail5


Medicine  
detail6


Medicine  
detail7


Medicine  
detail8


## Allergies

Are you allergic to any medications ☐ Yes ☐ No

List medicine to which you are allergic

What kind of reaction did you have

Constitutional  
☐ Lack of energy  
☐ Trouble sleeping  
☐ Loss of appetite  
☐ Weight changes  
☐ Fever

Heart  
☐ Blurred vision  
☐ Glaucoma  
☐ Cataracts  
☐ Buzzing or ringing in ears  
☐ Hay fever  
☐ Sinus problem

Respiratory  
☐ Wheezing  
☐ Cough  
☐ Coughing Blood  
☐ Asthma  
☐ Tuberculosis

Digestive  
☐ Indigestion  
☐ Change in bowel habits  
☐ Bloody or tarry stools  
☐ Jaundice  
☐ Liver problems  
☐ Ulcers  
☐ Gallstone

Urinary  
☐ Frequency  
☐ Infections  
☐ Stones  
☐ Bladder incontinence

Musculoskeletal  
☐ Joint pain  
☐ swelling or redness  
☐ arthritis  
☐ back pain  
☐ muscle aches  
☐ muscle tenderness  
☐ gout

Dermatological  
☐ Rash  
☐ Itching  
☐ other skin problems

Men  
☐ Prostate problems  
☐ night time urination

Women  
☐ Abnormal Menstrual periods  
☐ could you be pregnant

Female reproductive	<input type="checkbox"/> breast lumps <input type="checkbox"/> recent mamogram <input type="checkbox"/> pap smear or pelvic exam	Neurological	<input type="checkbox"/> Paralysis-even temporary <input type="checkbox"/> stroke <input type="checkbox"/> numbness <input type="checkbox"/> loss of balance <input type="checkbox"/> dizziness	Psychiatric	<input type="checkbox"/> Unusual thoughts <input type="checkbox"/> Nervousness <input type="checkbox"/> crying or sadness <input type="checkbox"/> depression <input type="checkbox"/> suicide attempts
---------------------	--	--------------	---	-------------	---

Endocrinology	<input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Excess thirst <input type="checkbox"/> Excess hunger <input type="checkbox"/> excess urination	Hematological	<input type="checkbox"/> Bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> risk factors for hiv <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer
---------------	---	---------------	--

Have you had any operations


Are you being treated now or have been treated for any illness


#### Social History

##### Marital

Marital status    ☐ single ☐ married ☐ widowed ☐ divorced

Occupation

Leisure activities

##### Health Habits:

Do you smoke        ☐ Yes ☐ No

How many packs per day

For how many years

Educational level

How much  
alcohol do you  
drink

Do you use  
any drugs

Family History:

Check if any close family members (parents, brothers and sisters, children) have:

Heart problems    ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ None

High blood pressure    ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ None

Diabetes    ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ None

cancer    ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ None

Hospitalizations:

Year

Hospital

Reason