Wilmington Cardiology

PATIENT HISTORY

General Information

Name:______________________ Date of Birth: ___/___/_____ Date of Visit: ___/___/_____

Name you preferred to be called:__________ Email address:______________________

Phone#: Home:__________ Work: __________ Cell:______________________

Reason for Visit:____

Who referred you to Wilmington Cardiology?______________________________

Who is your primary physician? ☐ Same as above ______________________________

Other physicians you see?____

Past Medical History

Have you ever been diagnosed with or told you have any of the following: (check all that apply)

☐ High Blood Pressure
☐ High Cholesterol/Triglycerides
☐ Heart Attack
☐ Congestive Heart Failure
☐ Atrial Fibrillation or Flutter
☐ Stroke or Transient Ischemic Attack
☐ Renal/Kidney Failure
☐ Thyroid Disease (Overactive/Underactive)
☐ Sleep Apnea (If yes, do you use CPAP____)
☐ Gastroesophageal Reflux
☐ Bleeding Ulcer
☐ Diverticular Disease
☐ Enlarged Prostate
☐ Pneumonia
☐ Gastrointestinal Bleed
☐ Valvular Heart Disease
☐ Emphysema/Chronic Obstructive Pulmonary Disease
☐ Cancer: (If yes, type______________________)
☐ Diabetes (Treated with: ☐ Diet ☐ Oral Medication ☐ Insulin)
☐ Other significant illnesses:____

____

Have you ever had any of the following cardiovascular procedures: (check all that apply and indicate information of most recent procedure)

	Date	Hospital/City/State	Physician
☐ Cardiac Catheterization	______	______________	__________
☐ Coronary Angioplasty/Stent	______	______________	__________
☐ Pacemaker/Defibrillator Placed	______	______________	__________
☐ Coronary Bypass Surgery	______	______________	__________
☐ Heart Valve Surgery	______	______________	__________
☐ Carotid Endarterectomy	______	______________	__________
☐ Peripheral Artery Angioplasty/Stent	______	______________	__________
☐ Peripheral Artery Bypass Surgery	______	______________	__________
☐ Electrophysiology Procedure	______	______________	__________

**(Please indicate if you have had multiple procedures)

DOB__________ NAME____ CHART #______

Non-Cardiac Surgical History

Have you ever had any of the following surgeries: (check all that apply)

- ☐ Cataract (Right/Left)
- ☐ Hernia (Hiatal/Inguinal/Incisional/Ventral)
- ☐ Hip (Right/Left)
- ☐ Breast
- ☐ Knee (Right/Left)
- ☐ Appendix
- ☐ Gall Bladder
- ☐ Back
- ☐ Hysterectomy
- ☐ Prostate
- ☐ Tonsils/Adenoids
- ☐ Other:____

Medication

Are you allergic to any medicines that you know of? ☐ Yes ☐ No

If yes, list:____

**********Please bring all medication, in their original containers, to each office visit**********

Medication Name	Dose	How often do you take

Social History

Where were you born?______________________ Where do you live?______________________

Occupation:______________________

Employment Status: ☐ Currently Employed ☐ Unemployed ☐ Disabled ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have children: ☐ Yes ☐ No If yes, give gender & ages:______________________

Tobacco Use: ☐ Never ☐ Past (Year Quit:________) ☐ Current

If past/current use: # of years you smoked:__________ __________# of packs per day

Alcohol use: ☐ Yes ☐ Past ☐ No

If yes: # of drinks per day:________ ☐ Beer ☐ Liquor ☐ Wine

History of substance abuse: ☐ Yes ☐ No If yes, explain:______________________

Do you follow a specific diet: ☐ Yes ☐ No If yes, explain:______________________

Do you drink caffeinated beverages: (coffee, tea, cola, etc) ☐ Yes ☐ No # per day__________

Do you exercise on a regular basis: ☐ Yes ☐ No If yes, type of exercise:______________________

Family History

Relatives	Age(s) Attained	Deceased?	Known Disease
Father			
Mother			
Brother(s)			
Sister(s)			
Child(ren)			

Comments:____