

### MEDICOR CARDIOLOGY

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331 U.S. Hwy. 206, Suite 1A Hillsborough, NJ 908-431-0600

Name \_\_\_\_\_ Date: / Allergies: \_\_\_\_\_

Reason for office visit: \_\_\_\_\_

Dear Patient, In order to give you the highest quality care please take a few minutes to complete this section about your PAST, FAMILY AND SOCIAL MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

**YOUR PAST MEDICAL HISTORY:** Please check each box if you have had the following problems:

- |                                      |   |  |             |
|--------------------------------------|---|--|-------------|
| <input type="checkbox"/> Angina      | <input type="checkbox"/> Heart Attack     | <input type="checkbox"/> Pacemaker       | Other _____ |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Heart Failure    | <input type="checkbox"/> Pass Out        |             |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Hiatal Hernial   | <input type="checkbox"/> Rheumatic Fever | Other _____ |
| <input type="checkbox"/> Bypass      | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |             |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Ulcer/Gastritis |             |
| <input type="checkbox"/> Dialysis    | <input type="checkbox"/> Murmur           | <input type="checkbox"/> Varicose Veins  | Other _____ |
| <input type="checkbox"/> Emphysema   | <input type="checkbox"/> Obesity          |  |             |

Surgeries: \_\_\_\_\_ Surgeries: \_\_\_\_\_

The following section is about your **FAMILY'S MEDICAL HISTORY:**

**Mother**

- |   |   |  |                  |
|---|---|--|------------------|
| <input type="checkbox"/> Living Age _____ | <input type="checkbox"/> Deceased Age _____ |  |                  |
| <input type="checkbox"/> Angina           | <input type="checkbox"/> Heart Failure      | <input type="checkbox"/> Pacemaker       | Other _____      |
| <input type="checkbox"/> Angioplasty      | <input type="checkbox"/> Hiatal Hernial     | <input type="checkbox"/> Pass Out        | Other _____      |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Rheumatic Fever | Other _____      |
| <input type="checkbox"/> Bypass           | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Stroke          | Surgeries: _____ |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Murmur             | <input type="checkbox"/> Ulcer/Gastritis | _____            |
| <input type="checkbox"/> Dialysis         | <input type="checkbox"/> Obesity            | <input type="checkbox"/> Varicose Veins  | _____            |
| <input type="checkbox"/> Emphysema        |   |  |                  |
| <input type="checkbox"/> Heart Attack     |   |  |                  |

**Father**

- |   |   |  |                  |
|---|---|--|------------------|
| <input type="checkbox"/> Living Age _____ | <input type="checkbox"/> Deceased Age _____ |  |                  |
| <input type="checkbox"/> Angina           | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Pacemaker       | Other _____      |
| <input type="checkbox"/> Angioplasty      | <input type="checkbox"/> Heart Failure      | <input type="checkbox"/> Pass Out        | Other _____      |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hiatal Hernial     | <input type="checkbox"/> Rheumatic Fever | Other _____      |
| <input type="checkbox"/> Bypass           | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Stroke          | Surgeries: _____ |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Ulcer/Gastritis | _____            |
| <input type="checkbox"/> Dialysis         | <input type="checkbox"/> Murmur             | <input type="checkbox"/> Varicose Veins  | _____            |
| <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Obesity            |  |                  |

**Brothers**

Number Living \_\_\_\_\_ Number Deceased \_\_\_\_\_

**Sisters**

Number Living \_\_\_\_\_ Number Deceased \_\_\_\_\_

- |                                      |   |  |                  |
|--------------------------------------|---|--|------------------|
| <input type="checkbox"/> Angina      | <input type="checkbox"/> Heart Attack     | <input type="checkbox"/> Pacemaker       |                  |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Heart Failure    | <input type="checkbox"/> Pass Out        | Other _____      |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Hiatal Hernial   | <input type="checkbox"/> Rheumatic Fever | Other _____      |
| <input type="checkbox"/> Bypass      | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          | Surgeries: _____ |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Ulcer/Gastritis | _____            |
| <input type="checkbox"/> Dialysis    | <input type="checkbox"/> Murmur           | <input type="checkbox"/> Varicose Veins  | _____            |
| <input type="checkbox"/> Emphysema   | <input type="checkbox"/> Obesity          |  |                  |

The following section is about your **SOCIAL HISTORY:** Check all boxes that pertain

Marital Status  Married  Divorced  Single  Separated  Widowed

Occupation(s) Exposure to:  Dusts  Asbestos  Other  
 Fumes  Chemicals

Exercise type(s) \_\_\_\_\_ Minutes \_\_\_\_\_ Days per week \_\_\_\_\_

Do you smoke?  Yes  No  Never Packs per day \_\_\_\_\_ Year quit \_\_\_\_\_

Do you drink alcohol?  Yes  No How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink caffeinated beverages?  No  Yes \_\_\_\_\_

**(PLEASE TURN OVER)**

Please take a few minutes to complete the following questions about symptoms you may be having. This will become part of your permanent record. Thank You!

SYSTEM REVIEW	QUESTIONS Do you have the following?:	NO	YES	COMMENTS
<b>Constitutional</b>	<b>Fever</b>	( )	( )	
	<b>Loss of appetite</b>	( )	( )	
	<b>Weakness</b>	( )	( )	
	<b>Weight gain or loss</b>	( )	( )	
<b>Eyes</b>	<b>Blurred vision</b>	( )	( )	
	<b>Double vision</b>	( )	( )	
<b>Ears Nose Throat</b>	<b>Dizziness</b>	( )	( )	
	<b>Hoarseness</b>	( )	( )	
	<b>Nosebleeds</b>	( )	( )	
<b>Cardiovascular</b>	<b>Chest pain</b>	( )	( )	
	<b>Difficulty climbing stairs</b>	( )	( )	
	<b>Dizziness</b>	( )	( )	
	<b>Leg swelling</b>	( )	( )	
	<b>Pain in the legs when walking</b>	( )	( )	
	<b>Palpitations</b>	( )	( )	
	<b>Passing out spells</b>	( )	( )	
	<b>Shortness of breath</b>	( )	( )	
<b>Respiratory</b>	<b>Asthma/Wheezing</b>	( )	( )	
	<b>Cough with or without phlegm</b>	( )	( )	
	<b>Shortness of breath while walking</b>	( )	( )	
	<b>Spit up blood</b>	( )	( )	
<b>Gastrointestinal</b>	<b>Blood in stool</b>	( )	( )	
	<b>Constipation/Diarrhea</b>	( )	( )	
<b>Genitourinary</b>	<b>Frequent urination</b>	( )	( )	
	<b>Impotent</b>	( )	( )	
<b>Musculoskeletal</b>	<b>Aching/sore muscles</b>	( )	( )	
	<b>Weakness</b>	( )	( )	
<b>Skin</b>	<b>Rash</b>	( )	( )	
<b>Neurologic</b>	<b>Tremor</b>	( )	( )	
	<b>Weakness of an extremity</b>	( )	( )	
<b>Psychiatric</b>	<b>Anxious</b>	( )	( )	
	<b>Depressed or sad</b>	( )	( )	
<b>Endocrine</b>	<b>Frequent urination/Urination at night</b>	( )	( )	
	<b>Intolerance to heat or cold</b>	( )	( )	
<b>Hematologic</b>	<b>Bleed or bruise easily</b>	( )	( )	
<b>Allergy/Immunology</b>	<b>Frequent infections</b>	( )	( )	
	<b>Seasonal runny nose, cough, wheezing</b>	( )	( )	

Please list your medications	Dose	Times per day	Allergies?
			_____
			_____
			_____
			_____
			_____
			_____
			_____
			_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature \_\_\_\_\_ Reviewing Physician \_\_\_\_\_

PLEASE REMEMBER TO BRING ALL YOUR MEDICATIONS TO YOUR APPOINTMENT