

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
Constitutional	Fever	()	()	
	Loss of appetite	()	()	
	Weakness	()	()	
	Weight gain or loss	()	()	
Eyes	Blurred vision	()	()	
	Double vision	()	()	
Ears Nose Throat	Dizziness	()	()	
	Hoarseness	()	()	
	Nosebleeds	()	()	
Cardiovascular	Chest pain	()	()	
	Difficulty climbing stairs	()	()	
	Dizziness	()	()	
	Leg swelling	()	()	
	Pain in the legs when walking	()	()	
	Palpitations	()	()	
	Passing out spells	()	()	
	Shortness of breath	()	()	
Respiratory	Asthma/Wheezing	()	()	
	Cough with or without phlegm	()	()	
	Shortness of breath while walking	()	()	
	Spit up blood	()	()	
Gastrointestinal	Blood in stool	()	()	
	Constipation/Diarrhea	()	()	
Genitourinary	Frequent urination	()	()	
	Impotent	()	()	
Musculoskeletal	Aching/sore muscles	()	()	
	Weakness	()	()	
Skin	Rash	()	()	
Neurologic	Tremor	()	()	
	Weakness of an extremity	()	()	
Psychiatric	Anxious	()	()	
	Depressed or sad	()	()	
Endocrine	Frequent urination/Urination at night	()	()	
	Intolerance to heat or cold	()	()	
Hematologic	Bleed or bruise easily	()	()	
Allergy/Immunology	Frequent infections	()	()	
	Seasonal runny nose, cough, wheezing	()	()	

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