Name: ______________________________ Date: ______________________

Date of Birth: ________________ Age: _______ Male ☐ Female ☐

Primary Care Physician: ____________________ Referring Physician: ______________________

Primary Pharmacy: ________________________________ Pharmacy Phone #: _____________

Briefly describe the reason for your visit:

____

____

Allergies:

Have you ever had a reaction to Iodine? Yes ☐ No ☐

Please list any other medication allergies:

Allergy to:	Reaction:
_________________________	_________________________
_________________________	_________________________

Medications:

Please list all medications (prescription and non-prescription) that you are currently taking:

Medication Name	Dosage	Frequency	Prescribing MD
_______________	__________	__________	____________________
_______________	__________	__________	____________________
_______________	__________	__________	____________________
_______________	__________	__________	____________________
_______________	__________	__________	____________________

Past Medical History:

Please list any medical conditions that you have: (ex: Diabetes, Hypertension, Cancer, Sleep Apnea, Thyroid disorders, etc)

____

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____

____

____

Past Surgical History:

Please provide the date for any that apply.

Tonsillectomy	______________	Gallbladder	______________	Knees	______________
Appendectomy	______________	Prostate	______________	Hips	______________
Hysterectomy	______________	Cataracts	______________	Hernia	______________

Other: ____

Previous Cardiac Procedures:	**Date**	**Location**	**Physician**
Heart Catheterization	______________	____________________	____________________
Stent Placement	______________	____________________	____________________
Coronary Artery Bypass Grafting	______________	____________________	____________________
Valve Replacement	______________	____________________	____________________
Electrophysiology Study	______________	____________________	____________________
Pacemaker/AICD Implant	______________	____________________	____________________
Stress Test	______________	____________________	____________________
Echocardiogram	______________	____________________	____________________
Holter Monitor	______________	____________________	____________________
CT/MRI	______________	____________________	____________________

Family History:

Does your father, mother, brother, sister, or grandparents have a history of heart disease such as a heart attack, stroke, stent placement, bypass surgery, or arrhythmias? Please list below.

☐ I am adopted

Relationship: __________________ Condition: ____________________ Age: __________ Deceased: Y N

Relationship: __________________ Condition: ____________________ Age: __________ Deceased: Y N

Relationship: __________________ Condition: ____________________ Age: __________ Deceased: Y N

Relationship: __________________ Condition: ____________________ Age: __________ Deceased: Y N

Social History:

Do you drink alcohol? ☐ Yes ☐ No

If yes, circle one of the following: Rare Frequent Social Occasional Daily

Do you have a history of drug abuse? ☐ Yes ☐ No

If yes, please specify: ____

Do you use tobacco? ☐ Yes ☐ No What kind? Cigarettes E-Cigarettes Pipes Smokeless

How many packs per day and for how long? ____

Have you previously used tobacco? ☐ Yes ☐ No When did you quit? ______________________________