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Patient Demographics

Patient's Last Name ____________________________ First Name _______________________ Middle Initial _______

SSN _____________________________ Date of Birth _______________ Age ___________ Gender F M

Address ______________________________ Apt. # _______ City ________________________ State _____ Zip ______

Race:

☐ American Indian/Alaska Native ☐ Asian ☐ White

☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _________________

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone ______________________________________ Day Phone ___________________________________

Email Address _____________________________________ Cell Phone ___________________________________

Employer _______________________________________ Occupation _______________________________ ☐Retired?

Employer Address ____

Emergency Contact _______________________________/_____________________ Phone _______________________

Name Relationship

Primary Care Physician Name: ____ Phone:__________________________

Referring Physician Name: ____ Phone: __________________________

Pharmacy Name: ____ Phone: _______________________________

Pharmacy Address: ____

Primary Insurance Coverage: ____

Policy Holder Name: _______________________________________ SSN:____________________ DOB:___________

Secondary Insurance Coverage: ____

Policy Holder Name: ______________________________________ SSN: ______________________ DOB: ___________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature ____ Date________________

Responsible Party Name ____ Relationship _______________

Patient History Form	
Name: ____	**Date of Birth:** _________________________

Reason for Visit:

____

____

Please List All Current Medications ☐ **Not Currently Taking Any Medications**

Medication Name	Dosage	How Often Taking	Medication Name	Dosage	How Often Taking

Allergies (e.g. medication, latex, egg) ☐ **No Known Allergies**

Allergen	Type of Reaction	Allergen	Type of Reaction

Past Medical History

☐	Anxiety Disorder	☐	Diverticulitis	☐	Kidney Disease
☐	Arthritis	☐	Fibromyalgia	☐	Kidney Stones
☐	Asthma	☐	Gout	☐	Leg/Foot Ulcers
☐	Bleeding Disorder	☐	Has Pacemaker	☐	Liver Disease
☐	Blood Clots (or DVT)	☐	Heart Murmur	☐	Osteoporosis
☐	Coronary Artery Disease	☐	Hiatal Hernia	☐	Polio
☐	Claustrophobia	☐	Reflux Disease / GERD	☐	Pulmonary Embolism
☐	Diabetes- insulin	☐	HIV or AIDs	☐	Ulcers
☐	Diabetes- Non-insulin	☐	High Cholesterol	☐	Stroke
☐	Dialysis	☐	High Blood Pressure	☐	Tuberculosis
☐	COPD	☐	Overactive Thyroid (hyper)	☐	Other
☐	Depression	☐	Underactive Thyroid (hypo)	☐	Heart Disease
☐	Hepatitis				

Female Patients: # of Children ___________/ # of C-sections: ___________ / # of Normal Deliveries: _____________

Cancer History

Cancer Type	Year Diagnosed	Treatment (e.g. chemo, radiation)	Year Treated

Patient Name: ____ Date of Birth: _______________

Please list any dietary restrictions: ____ ☐ None

Past Surgical History

Please list all past surgical procedures: ☐ **No Surgical History**

Surgical Procedure	Year	Surgeon

FAMILY HISTORY

☐ No family health information ☐ Unknown/Adopted

Relation	Alive?	Age	Significant Health History
Grandmother *(maternal)*	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Grandfather *(maternal)*	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Grandmother *(paternal)*	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Grandfather *(paternal)*	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Mother	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Father	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Brother/Sister	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Brother/Sister	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________
Other:	☐ Yes ☐ No		☐ Alcoholism ☐ Depression ☐ Genetic Disease ☐ Hypertension ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Cancer: ________

Patient Name: ____ Date of Birth: ____________________

Social History

Smoking Status:		
Smoking Tobacco Use History (all patients age 13 and older):		If there is a history of tobacco use:
☐ Never Smoker	☐ Current Every Day Smoker	Years Used: __________
☐ Former Smoker	☐ Current Some Day Smoker	Usage Per Day:__________
☐ Unknown if Ever Smoker	☐ Smoker Current Status Unknown	Age Stopped:____________

Alcohol Use:

Do You Consume Alcohol? ☐ No ☐ Yes ☐Former Frequency: _________ Amount: _________

Fall Risk:

Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: ___________

Did the fall(s) result in injury? ☐ Yes ☐ No

Lifestyle:

Sexual Preference: ☐ heterosexual ☐ homosexual ☐ bisexual

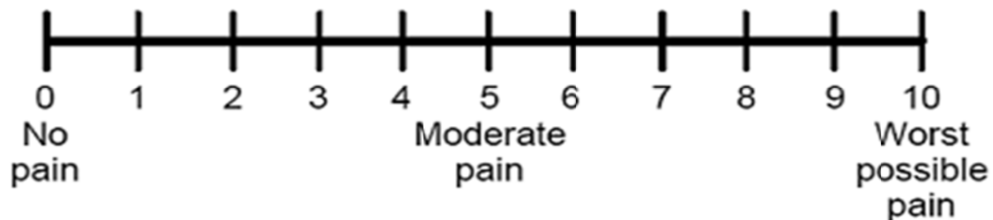
Advance Directives:

Do you have any Advance Directive documents? ☐ Yes ☐ No

(e.g. living will, power of attorney, do not resuscitate (DNR) orders)

Pain Scale:

Please indicate (circle) your current pain scale in relation to your current condition:



Cardiologist Name: ____ Phone: ____________________

Patient Signature: ____ Date: ____________________

Patient Representative Signature:__________________________________ Relationship: ________________