NORTHSIDE HEART

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Sex: Male**_____ **Female** _____

Primary Care Physician: _____

Referring Physician: _____

Reason for today's visit: _____

Medication	Dosage	Frequency (How Often)

Do you have any drug allergies? Yes No (If yes, please list below)

Medication Name: _____ Reaction: _____

Medication Name: _____ Reaction: _____

Medication Name: _____ Reaction: _____

Medication Name: _____ Reaction: _____

NEW PATIENT INTAKE FORM

Cardiac Risk Factors

History of heart disease? Yes No

___ Heart attack Date/Facility _____

___ Stents Date/Facility _____

___ Bypass surgery Date/Facility _____

History of stroke or mini stroke? Yes No Date _____

History of peripheral circulation problems? Yes No

Do you have a history of high blood pressure? Yes No

Do you have a history of diabetes mellitus? Yes No

Have you ever been told you have high cholesterol? Yes No

Medical History

Have you had any of the following cardiac studies? If yes, please list the date and location of testing below.

Exercise Treadmill Stress Test: Date of most recent test_____ Facility _____

Echocardiogram: Date of most recent test_____ Facility _____

Nuclear Stress Test: Date of most recent test_____ Facility _____

Any other diagnostic cardiology studies: Date of most recent test_____ Facility _____

Please check only the medical problems that apply to you:

___ Congestive Heart Failure
___ Cardiomyopathy
___ Atrial Fibrillation/Atrial Flutter
___ Pacemaker/Defibrillator
___ Cardioversion/Ablation
___ Heart Valve Disorder
___ Mitral Valve Prolapse
___ Heart Valve Surgery

___ DVT (Deep vein thrombosis/blood clot in legs)
___ PE (Pulmonary embolism/blood clot in lungs)
___ COPD (Pulmonary disease)
___ OSA (sleep apnea) CPAP Machine: Y N
___ Thyroid Disorder
___ GERD (Gastric Reflux)
___ Gastric Ulcer
___ Stomach or intestine Bleeding

___ Hepatitis
___ Kidney Disease
___ Enlarged Prostate
___ Dementia
___ Arthritis
___ Depression
___ Anxiety
___ Anemia
___ HIV/AIDS

___ Cancer: _____

_____

___ Other: _____

_____

Surgical History

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Family History

Does anyone in your family have a history of:

___ Heart disease (stents/heart attacks) Relationship/Age of diagnosis _____

___ Heart surgery Relationship/Age of diagnosis _____

___ Hypertension Relationship/Age of diagnosis _____

___ Diabetes mellitus Relationship/Age of diagnosis _____

___ Stroke Relationship/Age of diagnosis _____

___ Vascular problems Relationship/Age of diagnosis _____

Social History

___ Married ___ Single ___ Widowed ___ Children ___ Occupation _____

Tobacco (including chewing tobacco/vapor/e-cigarettes)

___ Current Age start/# of years _____ Amount per day _____

___ Former Age start/# of years _____ Amount per day _____

___ Never

Exercise _____ How often_____

Caffeine (coffee/teas/soft drinks) _____ How much _____

Alcohol _____ Current _____ Former How much _____

Other substance use (including marijuana, cocaine,other illicit drugs) _____