Patient History Questionnaire

CardiacCareAssociates, PC

Name: _____ **Date:** _____ **Age:** _____

Who is your family or primary care physician: _____

Do you have any medication allergies: _____

Do you have any food allergies: _____

Family History	*Father*	*Mother*	*Brother*	*Sister*
Coronary Artery Disease				
Stroke/CVA				
Diabetes				
High Cholesterol				
High Blood Pressure				

Your Past Medical History **Check box and circle choice where appropriate**	**Date of Onset**
☐ Chest Pain or Angina	
☐ Heart Valve Disorders	
☐ Arrhythmia / Palpitations	
☐ Congenital Heart Disease	
☐ COPD / Emphysema / Bronchitis / Asthma	
☐ Congestive Heart Failure	
☐ Diabetes: Type 1 or 2	
☐ High Cholesterol	
☐ Hypertension	
☐ Heart Attack / Coronary Artery Disease	
☐ Rheumatic Heart Disease	
☐ Syncope / Dizziness	
☐ Stroke / TIA	
☐ Heart Murmurs	
☐ Abnormal EKG	

Current Medications with Dosages

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____

Pharmacy Name: _____

Address: _____

_____

Phone # :

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other Number of Children: _____

Occupation: _____

Do you exercise routinely / type / amount: _____

History of Tobacco Use: ☐ Yes ☐ No History of Alcohol Use: ☐ Yes ☐ No

History of Caffeine Use: ☐ Yes ☐ No History of Illicit Drug Use: ☐ Yes ☐ No

What brings you to the office today? _____

_____

_____