CARDIAC CARE ASSOCIATES, P.C. **PATIENT HISTORY QUESTIONNAIRE**

Today's Date: _____

Name: _____ Date of Birth:_____

Do you have any medication allergies: _____
Do you have any food allergies: _____

List other Physicians treating you at this time:

_____
Name (1st and last) Specialty

_____
Name (1st and last) Specialty

_____
Name (1st and last) Specialty

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

Current Medications With Dosages
Pharmacy Name:
Address:
Phone #:

	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	

Social History:
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other Number of Children:_____
Your 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? _____
_____