Stuart Fischer, MD, FACC, FACP, FSCAI, CCDS
Timothy O'Neill, MD

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Ramandeep K. Brar, MD, FACC, FHRS
Robert S. Lee, MD

PATIENT HISTORY FORM

Name: ______________________________ Date: ____ /____ /____

Reason for your visit today: ______________________________

____

PAST MEDICAL HISTORY

Medical Problems: ______________________________

____

____

Operations: ______________________________

____

____

Allergies to Medications: ______________________________

____

____

Medications You Are Now Taking: ______________________________

____

____

SOCIAL HISTORY

Smoke: ______________________________

____

Alcohol: ______________________________

____

Occupation: ______________________________

Change in Weight Recently: ______________________________

MEDICAL HISTORY IN FAMILY

Father: ______________________________

Mother: ______________________________

Brothers: ______________________________

Sisters: ______________________________

Grandparents: ______________________________

Others: ______________________________

SYMPTOM REVIEW

PLEASE MARK THE APPROPRIATE BOX

SYMPTOM	NEVER	SOMETIMES	FREQUENTLY
Chest Pain	☐	☐	☐
Shortness of Breath at Rest	☐	☐	☐
Shortness of Breath with Exercise	☐	☐	☐
Ankle Swelling	☐	☐	☐
Palpitation	☐	☐	☐
Cough	☐	☐	☐
Phlegm (Mucus)s	☐	☐	☐
Cough Blood	☐	☐	☐
Indigestion	☐	☐	☐
Vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Blood in Stool	☐	☐	☐
Black Stool	☐	☐	☐
Painful or Bloody Urine	☐	☐	☐
Vaginal Bleeding (Females)	☐	☐	☐
Slow Urinary System	☐	☐	☐
Arthritis	☐	☐	☐
Paralysis	☐	☐	☐
Tingling in Arms / Legs / Both	☐	☐	☐
Leg Cramps	☐	☐	☐
Seizures	☐	☐	☐
Easy Bruising	☐	☐	☐

Name: ____
(SIGNATURE)

Date: _______ /_______ /_______