Valley Medical Group
Valley Health System

Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY – Cardiology

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ (☐ Home ☐ Cell ☐ Work) E-Mail: _____

Primary Insurance Company: _____ Policy #:_____

Primary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Secondary Insurance Company: _____ Policy #:_____

Secondary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ Aspirin		☐ Latex	
☐ Doxycycline		☐ Other:	
☐ Erythomycin		☐ Other:	
☐ Macrobid		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Sulfa		☐ Other:	

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking)

Name of Medication/Herb/Vitamin	**Dosage** (mg/ml)	**Frequency**

Patient Name: _____ Date of Birth: _____

VACCINES (Please check all vaccines that you have had & the date in which the vaccine was given)

Vaccine	Date	Vaccine	Date	Vaccine	Date
☐ Chicken Pox (Varicella)		☐ Influenza		☐ Polio	
☐ DTaP/DTP		☐ Lyme		☐ Rabies	
☐ Hepatitis A		☐ Measles/Mumps/Rubella		☐ Shingles (Herpes Zoster)	
☐ Hepatitis B		☐ Meningococcal		☐ Td (Adult) (tetanus & diphtheria)	
☐ Hepatitis C		☐ Pneumococcal		☐ Tdap	
☐ HIV		☐ Pneumovax		☐ Tetanus	
☐ HPV (Gardasil)		☐ Other:		☐ Other:	
☐ HPV (Cervarix)		☐ Other:		☐ Other:	

CHIEF COMPLAINT TODAY (Please check the reason for your visit today)

	☐ Edema	☐ Palpitations
☐ Arm Pain	☐ Established Patient	☐ Peripheral Vascular Disease
☐ Arrhythmia	☐ Event Monitor	☐ Post-op
☐ Atrial fibrillation	☐ GERD	☐ Pt/INR Check
☐ Cardiomyopathy	☐ Hospital Follow-up	☐ Shortness Of Breath
☐ Chest pain	☐ Hyperlipidemia	☐ Syncope
☐ Congestive heart failure	☐ Hypertension	☐ Treadmill Stress Test
☐ Coronary artery disease	☐ Leg pain	☐ Valvular Heart Disease
☐ Diabetes	☐ Murmur	☐ Venticular Tachycardia
☐ Dizziness	☐ New Patient	☐ Other:
☐ Dyslipidemia	☐ Nuclear Stress Test	☐ Other:
☐ Echo	☐ Pacemaker check/programming	☐ Other:

PAST MEDICAL HISTORY (Please check those items that apply)

☐ Anemia	☐ Gastrointestinal Disease	☐ TIA
☐ Aortic Aneurysm	☐ Genitourinary Disease	☐ Valvular Abnormalities
☐ Arrhythmia	☐ Hematologic Disease	☐ Valvular Heart Disease
☐ Atrial Fibrillation	☐ Hyperlipidemia	☐ Ventricular Tachycardia
☐ Atrial Flutter	☐ Myocardial Infarction	☐ Warfarin Management
☐ Blood Clot	☐ Neurologic Disorder	☐ Other:
☐ Cardiomyopathy	☐ Pacemaker	☐ Other:
☐ Carotid Disease	☐ Peripheral Arterial Disease	☐ Other:
☐ Congenital Heart Disease	☐ Sleep Apnea	☐ Other:
☐ Congestive Heart Failure (CHF)	☐ Sleep Disorder	
☐ Deep Vein Thrombosis	☐ Thyroid Disease	

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SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	Date of Surgery	Procedure	Date of Surgery
☐ Abdominal Surgery		☐ Orthopedic Surgery	
☐ AICD		☐ Pacemaker	
☐ Cardiac Catheterization		☐ Stent	
☐ Cardiac Surgery		☐ Tonsillectomy/Adenoidectomy	
☐ Cardioversion		☐ Vascular Surgery	
☐ Coronary Artery Stent		☐ Other:	
☐ Gastrointestinal Surgery		☐ Other:	
☐ Genitourinary Surgery		☐ Other:	
☐ HEENT Surgery		☐ Other:	

FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Arthritis			
☐ CAD			
☐ Coronary Artery Disease			
☐ Heart Disease			
☐ Heart Failure			
☐ Myocardial Infarction			
☐ Myocardial Infarction at young age			
☐ Pulmonary Disease			
☐ Sudden Cardiac Death			
☐ Other:			
☐ Other:			
☐ Other:			
☐ Other:			

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SOCIAL HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Live alone or with others? ☐ Alone ☐ With Others Number of Children: _____

General Stress Level: ☐ Low ☐ Medium ☐ High

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Specific ☐ Carbohydrate ☐ Cardiac ☐ Diabetic

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day ☐ Current Status Unknown

Smoking – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week

Has Smoked Since Age: _____ Tobacco– Years of Use: _____

Chewing Tobacco? ☐ None _____ 1/ Per Day _____ 2-4/ Per Day _____ 5+/ Per Day

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit Drugs: _____ Illicit Drugs- Years of Use: _____

Advance Directive? ☐ Yes ☐ No