

NEW PATIENT HISTORY FORM (PLEASE ANSWER ALL QUESTIONS)

Name: _____ Date: _____

Primary Care Physician: _____ Atlanta Heart MD: _____

What problem brings you to our office today? _____

PAST MEDICAL HISTORY (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Myocardial Infarction (heart attack) | <input type="checkbox"/> COPD / Lung Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Autoimmune Disorders |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Burn/Peptic Ulcers/Reflux |
| <input type="checkbox"/> Diabetes (sugar) | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Other _____ |

List all Surgeries: _____

List all Allergies: _____

List all Medications: _____

FAMILY HISTORY (check all that apply)

Heart Disease
 High Blood Pressure
 Stroke
 Heart Attack
 Cancer
 High Cholesterol
 Diabetes
 Seizures
 Pacemaker Treatment
 Congenital Defects

	Heart Disease	High Blood Pressure	Stroke	Heart Attack	Cancer	High Cholesterol	Diabetes	Seizures	Pacemaker Treatment	Congenital Defects
Father										
Mother										
Siblings										

SOCIAL HISTORY / RISK FACTORS

- Smoker: Yes _____ packs per day No Date Quit ____/____/____
- Alcohol: Yes _____ drinks per day No
- Caffeine: Yes _____ drinks per day No
- Exercise: Yes, How often? _____ No

REVIEW OF SYSTEMS (Please check any problems you are having.)

- | | | | |
|----------------|--|---------------|---|
| CARDIO: | <input type="checkbox"/> Chest pain | GI: | <input type="checkbox"/> Nausea/Vomiting |
| | <input type="checkbox"/> Palpitations (chest fluttering) | | <input type="checkbox"/> Heartburn/Reflux |
| | <input type="checkbox"/> Edema (swelling) | GU: | <input type="checkbox"/> Urinary/bladder problems |
| | <input type="checkbox"/> Sleeping on more than 1 pillow | | <input type="checkbox"/> (Male) Prostate problems |
| | <input type="checkbox"/> Syncope (passing out) | MUSC: | <input type="checkbox"/> Joint pain |
| RESP: | <input type="checkbox"/> Shortness of breath | | <input type="checkbox"/> Muscle pain |
| | <input type="checkbox"/> Shortness of breath with activity | | <input type="checkbox"/> Muscle weakness |
| | <input type="checkbox"/> Shortness of breath lying flat | NEURO: | <input type="checkbox"/> Dizziness |
| | <input type="checkbox"/> Cough | | <input type="checkbox"/> Tingling/numbness |
| | <input type="checkbox"/> Wheezing | SKIN: | <input type="checkbox"/> Rashes |
| | <input type="checkbox"/> History of snoring | | <input type="checkbox"/> Ulcers on feet |
| CONST: | <input type="checkbox"/> Fatigue | HEM: | <input type="checkbox"/> Unexplained bruising |
| ENMT: | <input type="checkbox"/> Difficulty swallowing | | <input type="checkbox"/> Bleeding disorder |

I am having no problems

Patient Signature _____