

**SHORE HEART GROUP, PA**

DATE \_\_\_\_\_  
LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ AGE \_\_\_\_\_  
REFERRING PHYSICIAN \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

*What is the problem you have been having?*

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**ALLERGIES:** \_\_\_\_\_ *Recent testing done?* \_\_\_\_\_  
*Have you ever had a heart catheterization?* \_\_\_\_\_ *Angioplasty?* \_\_\_\_\_ *Bypass Surgery?* \_\_\_\_\_  
*Previous echocardiogram?* \_\_\_\_\_ *Previous carotid ultrasound?* \_\_\_\_\_ *Previous stress test?* \_\_\_\_\_

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**MEDICATIONS:** Please list ALL medications, prescription or non-prescription, which you are "CURRENTLY" taking and include how many times per day you are taking them and the strength:

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Do you take Aspirin or other Blood thinners? \_\_\_\_\_ Herbal medications \_\_\_\_\_ Vitamins? \_\_\_\_\_

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**PAST MEDICAL HISTORY:** *Hospitalizations or Operations?*

Year	Reason for Hospitalization	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

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**REVIEW OF SYSTEMS:** *Do you have any of the following? Yes or No*

Heart Problems _____	Asthma _____	Kidney Problems _____
Murmur/Valve Problem _____	COPD _____	Bladder Problems _____
High Blood Pressure _____	Emphysema _____	Prostate Problems _____
Irregular Heart Beat _____	Breathing Problems _____	Seizure Disorders _____
Chest Pain _____	Anemia _____	Arthritis _____
CVA, TIA _____	Thyroid Problems _____	Stomach Problems _____
Peripheral Vascular Problems _____		
Please list any other Medical Conditions _____		

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**FAMILY HISTORY:** Any immediate family members have a history of the following?

Diabetes _____	High Blood Pressure _____	Cancer _____	Anemia _____
Asthma _____	High Cholesterol _____	Arthritis _____	Thyroid Problems _____
Heart Disease _____	Stroke _____	Kidney Problems _____	Pancreatic Problems _____

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**SOCIAL HISTORY:**

Occupation _____	Marital Status? _____	Children (ages) _____
Do you smoke? _____	If yes, how much? _____	Do you drink coffee, tea? _____ Cups per day? _____
Do you drink alcohol? _____	If yes, how much? _____	Do you experience high anxiety? _____
Do you follow a special diet? _____		

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FOR STAFF USE

- ♣ Recent Testing Results Received \_\_\_\_\_
- ♣ Medical Records Release Received \_\_\_\_\_
- ♣ Hospitalization Records Received \_\_\_\_\_