SHORE HEART GROUP, PA

DATE _____

LAST NAME _____ FIRST NAME _____ AGE _____

REFERRING PHYSICIAN _____ Height: _____ Weight: _____

What is the problem you have been having?

_____

ALLERGIES: _____ *Recent testing done?* _____

Have you ever had a heart catheterization? _____ *Angioplasty?* _____ *Bypass Surgery?* _____
Previous echocardiogram? _____ *Previous carotid ultrasound?* _____ *Previous stress test?* _____

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? _____

PAST MEDICAL HISTORY: *Hospitalizations or Operations?*

Year	Reason for Hospitalization	Diagnosis

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 _____

_____

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	

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? _____

FOR STAFF USE

- ♣ Recent Testing Results Received _____
- ♣ Medical Records Release Received _____
- ♣ Hospitalization Records Received _____