Capital Cardiology Associates

Name:____**Date:**____________________**DOB:**_______________

For Med Assistant Entry: Height__________ ***Weight***____________ ***BP***________________ ***HR***________________

1) Reason for Visit:

____

____

2) How did this come about, explain as much as needed:

____

____

3) Cardiac Risk Factors

Risk Factor	Self	Family	Risk Factor	Self	Family
Smoking			High Blood Pressure		
Heart Disease			Sedentary Life Style		
Diabetes			Alcohol/Substance Abuse		
High Cholesterol			Previous Heart Attack		

4) What are your main medical problems (list all you know about): (Past Medical Hx)

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Hospitalizations: List non-surgical hospitalizations

Hospital	Reason for hospitalization	Date

Past surgery including non-hospital surgeries:

Hospital	Reason for surgery	Date

Any other Medical History:____

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Capital Cardiology Associates

Social History	
Marital Status: S M D Oth_________	**# of Children:**
Parents/Siblings Still Living: Yes No **If deceased, give age deceased and cause:** **Mother:**___________________________________ **Father:**____________________________________ **Sibling:**___________________________________	**Smoking:** Cigarettes Cigars Chew E-Cig How Many? ________ per________ ____Former Smoker When did you quit?_________ How Many? _________per __________ ____Occasional Smoker ___Never Smoker
Daily Exercise: Yes No **What kind of exercise?**	**Alcohol/Recreational Drugs?**___________________ **How many?**______________ per __________
Are you under a lot of stress? Yes No **Explain:**	**What kind of work do you do?**
Family History: List anyone in your immediate family who has a heart condition, including heart attacks, stents, bypass surgery:	

Current Medications:			
Drug	**Dosage**	**# taken/day**	**Ordering MD**

List Allergies to Drugs and Other Substances:	
Allergy	**What kind of reaction did you get?**

(ROS): Please Check All That Apply:

CARDIAC: See History of Present Illness

RESPIRATORY: ____Wheezing ____Cough ____Sputum Production ____No Problems

CONSTITUTIONAL: ____Fever ____Chills ____Night Sweats ____Significant changes in weight ____No Problems

EYES: ____Blurry Vision ____Double Vision ____No Problems

GI: ____Abdominal Pain ____Nausea/Vomiting ____Diarrhea ____No Problems

GENITOURINARY: ____Burning ____Urinary Retention ____Frequent Urinary Tract Infections ____No Problems

MUSCULOSKELETAL: ____Aches ____Pains ____Joint Swelling ____No Problems

ENDOCRINE: ____Heat/Cold Intolerance ____Unexplained Thirst ____Increased Urination ____No Problems

NEUROLOGICAL: ____Seizures ____Paralysis ____Significant Headaches ____No Problems

SKIN: ____Rash ____Itching ____New Skin Lesions ____No Problems

DOCTOR'S NOTES: