CARDIOLOGY ASSOCIATES OF GAINESVILLE
(352) 375-1212

PATIENT HISTORY FORM

Please complete this form to the best of your ability.

DATE	Office 6E MICU SICU Other
Name	M F Age Birth date
Address	
Phone	Social Security Number
Primary Physician	Cardiologist
In case of emergency notify	
Present insurance	

What is your social history?

Married - Widowed - Single - Divorced - Separated
Currently employed
Type of work
Retired (when)
Disabled (when)
Highest level of education

What is your main concern or problem?

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____

Briefly list any prior operations or hospitalizations:

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Do you have any risk factors for heart disease?	**Yes**	**No**
Hypertension		
Sugar diabetes		
High cholesterol or triglycerides		
Smoking		
History of rheumatic fever		
Family history of heart disease before age 60		

Have you had any laboratory work done recently? If so, where?	**Yes**	**No**
Lab work		
Cholesterol & triglyceride levels		
Blood sugar		

Health professional initials __________

Have you ever had any of the following tests done? If so, when and where?	Yes	No
Stress Test		
Echocardiogram		
Heart Catheterization		
Holter monitor		
Event recorder		

What is your cardiac history?	Yes	No
Heart attack (myocardial infarction)		
Heart surgery (bypass, valve repair or replacement)		
Valvular heart disease		
Congenital (at birth) heart defect		
High blood pressure		
Atrial fibrillation/ atrial flutter		
Pacemaker or defibrillator		
Syncope (passing out or fainting spells)		

Do you presently have any of the following cardiac symptoms?	Yes	No
Fast or slow heart rate		
Shortness of breath		
Palpitations or skipped beats		
Chest discomfort or pressure		
Wake up at night short of breath		
Have to prop up on pillows or sit up at night to breathe		
Swelling in ankles		
Fatigue		

Do you have any of the following conditions?

Stroke/TIA		Thyroid problems		Gout	
Blocked carotid arteries		Seizures		Arthritis	
Chronic lung disease		Migraines		Kidney disease	
Asthma		Mental illness		Cancer	
Pneumonia		Reflux/Hiatal Hernia		Sleep apnea	
Glaucoma		Stomach ulcers		Gallbladder	
Impotence or Erectile dysfunction		Is there a possibility you could be pregnant?		Peripheral vascular disease (poor circulation or leg pain)	

What is your family history (parents, siblings, and your children)?

Relative	**Age**	**Age at death**	**Major illness or cause of death** (Heart disease, stroke, high blood pressure, diabetes, kidney disease)?
Father			
Mother			
Brothers			
Sisters			

What are your habits? Please describe.

Tobacco use: Packs/day? How many years? Quit date?
Alcohol use: How much per week?
Recreational drug use? Marijuana Other
Caffeine (coffee, soda, tea, chocolate):
Regular exercise program?

Do you have any of the following symptoms?	**Yes**	**No**
Inability to do routine activities		
Recent weight gain or loss		
Skin problems		
Headaches		
Dizziness		
Change in vision		
Change in hearing		
Sinus pain		
Dental problems		
Leg pain with ambulation		
Leg cramps		
Chronic cough		
Bleed or bruise easily		
Constipation or diarrhea		
Rectal bleeding/Black or tarry stool		
Nausea or vomiting		
Urinary frequency or change in urine stream		
Joint pain or swelling		
Chronic back or neck pain		
Loss of memory		
Unsteadiness or loss of balance		
Numbness or tingling		
Intolerance to heat or cold		
Depressed		
Reported loud snoring/choking/stop breathing while sleeping		
Fall asleep during the day even if you are trying to stay awake		

What are your current medications?

Name	**Dose**	**Frequency**

Medication allergies
Allergy to contrast dye, iodine, seafood or shellfish?

Do you take any herbal products or non-prescription medications?

RELEASE OF MEDICAL RECORDS

To: ____

FAX: ____

Request: ____

Please release the requested medical records to:

Michael C. Dillon, M.D., F.A.C.C.
Bernard J. Gros, M.D., F.A.C.C.
James J. O'Meara, III, M.D., F.A.C.C.
Steven F. Roark, M.D., F.A.C.C.
Burton V. Silverstein, M.D., F.A.C.C.
Andrew L. Smock, M.D., F.A.C.C.

Cardiology Associates of Gainesville
4645 NW 8th Ave.
Gainesville, FL 32605

Phone: (352) 375-1212

FAX: (352) 377-3010

Patient Name	
Date of Birth	
Social Security number	
Medical record number	

Patient signature ____

Date______________