Patient Name: _____ Date: _____

Home Medications

List all medications & dosage you are presently taking and how frequently you take them:

Medication / Dose / Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all known allergies:

_____
_____
_____
_____
_____

Family History

Please check and add any details out to the side

Please circle family member(s) where applicable

☐ Unknown	[father, mother, sibling, grandparent]
☐ Aortic Aneurysm	[father, mother, sibling, grandparent]
☐ Asthma	[father, mother, sibling, grandparent]
☐ Bleeding Disorder	[father, mother, sibling, grandparent]
☐ Cancer _____	[father, mother, sibling, grandparent]
☐ Congestive Heart Failure	[father, mother, sibling, grandparent]
☐ Connective Tissue Disease	[father, mother, sibling, grandparent]
☐ Coronary Artery Disease	[father, mother, sibling, grandparent]
☐ Coronary Heart Disease-male < 55	[father, sibling, grandparent]
☐ Coronary Heart Disease-female < 55	[mother, sibling, grandparent]
☐ CVA or Stroke	[father, mother, sibling, grandparent]
☐ Diabetes	[father, mother, sibling, grandparent]
☐ Hyperlipidemia (cholesterol problems)	[father, mother, sibling, grandparent]
☐ Hypertension	[father, mother, sibling, grandparent]
☐ Marfan's Syndrome	[father, mother, sibling, grandparent]
☐ PAH (Pulmonary Artery Hypertension)	[father, mother, sibling, grandparent]
☐ Peripheral vascular disease	[father, mother, sibling, grandparent]
☐ Prolonged QT	[father, mother, sibling, grandparent]
☐ Renal Disease	[father, mother, sibling, grandparent]
☐ Sudden Cardiac Death	[father, mother, sibling, grandparent]
☐ Thyroid Disease	[father, mother, sibling, grandparent]

Mother living? Yes No Age at death _____ Father living? Yes No
Age at death _____ Number of living brothers & sisters _____ Number of deceased brothers & sisters _____

Social History

Marital Status: Single, Married, Divorced, Widowed

How many children do you have? _____

What is your occupation: _____

Disabled Retired

Smoking History:

Current Smoker: year started _____

Cigarettes: _____ packs per day

Cigars: _____ number per week

Smokeless: _____ amount per day

Counseled to quit or cut down: Yes No

Former smoker: year quit _____

Never smoked:

Passive smoke exposure Yes No

Do you drink alcoholic beverages? Yes No

Types of Alcohol? _____

How many drinks per day? _____

Drug Use? Yes No (If yes circle type below)

Marijuana, cocaine, crack, heroin, illicit prescription
Other _____

Do you drink caffeinated drinks? Yes No

How many per day? _____

Do you drink diet drinks? Yes No

Are you on a special diet? Yes No

Calorie Limited Low Salt
Low Fat Diabetic
High Fiber Low Cholesterol
Other _____

Do you exercise on a regular basis? Yes No
How many times per week? _____
Type of exercise? _____

Do you have a barrier to communication? Yes No
(If yes, circle impairment below)

Non-English Speaking Hearing Impairment
Vision Impairment

High Risk Behavior? Yes No

Comments: _____