Atlantic Cardiology

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Name	SS#	Date
Address	Occupation	
DAYTIME Phone: _____ CELL Phone: _____	Work Phone	Date of Birth / Age
Chief Complaint		

Past Medical History

☐	Heart Problems: If so specify:
☐	High Blood Pressure
☐	Diabetes
☐	High Cholesterol
☐	Stroke
☐	Poor circulation/vascular problems
☐	Other, Please List: Use additional sheets if necessary

Past Surgical History

☐	Coronary bypass surgery
☐	Surgery on other blood vessels
☐	Other Surgeries, please list:
☐	Coronary Angioplasty
☐	Coronary Stents. If Yes, How Many?

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Sudden Death	☐	☐	☐	☐	☐	☐
Vascular	☐	☐	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐	☐

Social History

Do you smoke?	Yes ☐	No ☐
If yes, how much?	Yes ☐	No ☐
If you quit, how long ago?	Yes ☐	No ☐
How many alcoholic drinks/week do you drink?		
Any History of IV Drug Use / Street Drugs?	Yes ☐	No ☐
IF YES, PLEASE LIST:		
Do you have any food allergies?	Yes ☐	No ☐
Please list foods:		

Medication Allergies

DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO

MEDICATION LIST

PATIENT NAME: _____ DOB: _____

MEDICATION	DOSAGE	HOW OFTEN TAKEN

PHARMACY: _____
PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____
PHONE NUMBER: _____

***<u>PLEASE NOTE</u>: *ONLY CARDIAC MEDICATIONS WILL BE REFILLED BY OUR PHYSICIANS. DO NOT WAIT UNTIL YOU ARE OUT/ALMOST OUT OF MEDICATION SINCE THE PHARMACY CAN TAKE 1-2 DAYS FOR REFILLS TO BE READY.*

****ANY OTHER MEDICATIONS WILL NEED TO BE FILLED BY YOUR PRIMARY CARE PHYSICIAN****

Thank you for your understanding.