

Grand Rapids Cardiology New Patient Form

Date _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Sex _____ Marital Status M S W D DOB _____

Social Security Number _____

Primary Care Physician _____

Emergency Contact Person _____

Phone _____ Relationship _____

Primary Insurance _____ Group # _____

Contract Number _____

Subscriber's Name _____ DOB _____

Secondary Insurance _____ Group # _____

Contract Number _____

Subscriber's Name _____ DOB _____

Reason for Visit _____

Allergies _____

Medications	Dosage	Frequency
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History (Please circle if have ever had)

Congestive Heart Failure

Irregular Heart Rhythm

Heart Valve Disease

Asthma/Lung Disease

Emphysema

Cancer

Claudication/Peripheral Vascular Disease

Kidney Disease

High Blood Pressure

High Cholesterol

Rheumatic Fever

Stomach Ulcer

Thyroid Disease

Stroke/TIA

Diabetes

Acid Reflux

Other _____

Heart Attack **Date** _____

Heart Catherization **Date** _____

PTCA/Angioplasty **Date** _____

Stent Placement **Date** _____

Past Surgeries

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

Social History

Do You Smoke? Y N

Former Smoker? Y N

When did you quit? _____

How many packs per day? _____

How long have you smoked? _____

Do you drink alcohol? Y N

Amount per week _____

Type _____

Exercise sedentary active lifestyle routine

What type of exercise _____

Family History

	Age	Living/Deceased	Conditions
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Current Symptoms

	Onset	Duration	Frequency	Severity
Relieving/Aggravating				
Shortness of Breath				
Chest Pain				
Dizziness				
Rapid Heart Rate/Palpitations				
Pain in legs when walking				
Swelling of Legs				
Fainting				
Fatigue				
Nausea				