# 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 __________________________________

Reason for visit ____________________________________________________________

____________________________________________________________________________

**Allergies** ______________________________________________

| **Medications** | **Dosage** | **Frequency** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Past Medical History (please circle if you ever had...)

Congestive Heart Failure

Irregular Heart Rhythm

Heart Valve Disease

Asthma/Lung Disease

Emphysema

Cancer

Claudication/Peripheral Vascular Disease

Kidney Disease

Other ______________________

High Blood Pressure

High Cholesterol

Rheumatic Fever

Stomach Ulcer

Thyroid Disease

Stroke/TIA

Diabetes

Acid Reflux

Heart Attack Date ______________________

Heart Catherization Date ______________________

PTCA/Angioplasty Date ______________________

Stent Placement Date ______________________

## Past Surgeries

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

## Social History (please circle if applicable)

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 ______________

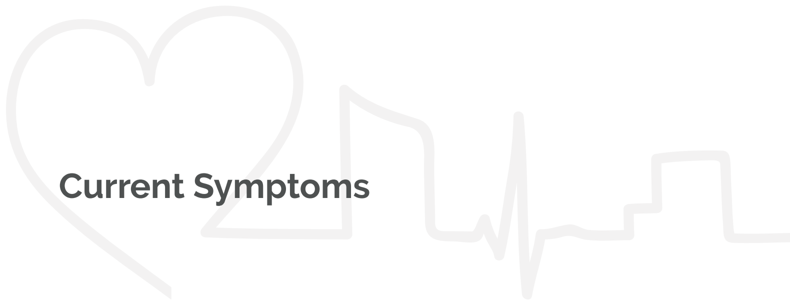
Type ______________

Exercise Sedentary Active Lifestyle Routine

What type of exercise ______________________________

## Family History

| | Age | Living/Deceased | Conditions |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Siblings | | | |
| | | | |
| | | | |



## Current Symptoms

| | Relieving/Aggravating | Onset | Duration | Frequency | Severity |
|---|---|---|---|---|---|
| Shortness of Breath | | | | | |
| Chest Pain | | | | | |
| Dizziness | | | | | |
| Rapid Heart Rate/Palpitations | | | | | |
| Leg Pain When Walking | | | | | |
| Swelling of Legs | | | | | |
| Fainting | | | | | |
| Fatigue | | | | | |
| Nausea | | | | | |