## HISTORY & PHYSICAL 1.3

**NAME** _____ **AGE** _____ ACCOUNT _____ DATE _____
**REASON FOR VISIT/CHIEF COMPLAINT**_____
_____
_____
**BP LEFT** _____ **BP RIGHT** _____
**PAST MEDICAL HISTORY** (if yes, number of years and treatment)

ANGINA YES/NO_____
M.I./CHF YES/NO_____
STROKE YES/NO_____
DIABETES YES/NO_____
HEPATITIS/BLOOD DISORDER YES/NO_____
CANCER YES/NO_____
LUNG YES/NO_____
BOWEL/KIDNEY PROBLEMS YES/NO_____
HYPERTENSION YES/NO_____
OTHER MEDICAL PROBLEMS_____
_____
_____
_____
ARE YOU PREGNANT (circle one) YES / NO If yes, how far along? _____

**PAST SURGICAL HISTORY** (operation & date)

SURGERY _____ DATE _____
SURGERY _____ DATE _____
SURGERY _____ DATE _____
SURGERY _____ DATE _____
SURGERY _____ DATE _____
SURGERY _____ DATE _____
SURGERY _____ DATE _____
SURGERY _____ DATE _____
SURGERY _____ DATE _____

**SOCIAL HISTORY** (circle one) MARRIED / DIVORCED / WIDOWED / SINGLE

**JEHOVAH WITNESS** ____Yes ____No

**SMOKE** (circle one) YES / NO / NEVER SMOKING/SMOKED HOW LONG ____mos ____yrs PACKS/DAY ____

IF QUIT, HOW LONG AGO ____mos ____yrs

**ALCOHOL/SUBSTANCE USAGE** _____

**NAME** _____ ACCOUNT_____ DATE _____

**MEDICATIONS** (type/dose/frequency)

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**ALLERGIES** _____

_____

PHARMACY (location & phone) _____

**FAMILY HISTORY**

MOTHER ALIVE _____ AGE _____ DECEASED _____ CAUSE/ILLNESS _____

FATHER ALIVE _____ AGE _____ DECEASED _____ CAUSE/ILLNESS _____

SIBLINGS # BROTHERS _____ # SISTERS _____

(circle) A or D (cause)_____ A or D (cause)_____

A or D (cause)_____ A or D (cause)_____

A or D (cause)_____ A or D (cause)_____

A or D (cause)_____ A or D (cause)_____

A or D (cause)_____ A or D (cause)_____

A or D (cause)_____ A or D (cause)_____

EMERGENCY CONTACT _____ RELATION _____ PHONE _____

AUTHORIZATION TO RELEASE RECORDS TO BE COMPLETED if patient is authorizing *Atlantic Cardiovascular* to release information via telephone, facsimile or US Mail to family member, caretaker or friend (7.1 form). One form per person of note.

HEALTH CARE SURROGATE _____ LIVING WILL _____ ON FILE WHERE _____

COMMENTS _____

_____

_____

_____

_____

_____

COMPLETED BY *(office use only)* _____