Khoury Cardiology, PA

Date Completed: ______________________________ **Appointment Date:** ____________________

Name: ____ **Age:** ________ **Birthdate:** ____/____/_____

FIRST MIDDLE INITIAL LAST

Referred by: ________________________________ **Family Dr.:** __________________________

Reason for visit:

____

____

Family History:

	Age	Serious Health Problems	Age at Death if deceased	Cause
Father				
Mother				
Brother(s)				
Sisters(s)				
Children				

Social History:

Single ____ Married ______ Widowed _______ Divorced ________

Education: ____

Last grade of school completed: ____

Current/Prior Occupation: ____

Do you smoke cigarettes? ____ no _____ yes - how much _________________ how long? ____________

Do you chew tobacco? ____ no _____ yes - how much _________________ how long? ____________

Do you drink alcohol? ____ no _____ yes - how much _________________ how long? ____________

Do you use illegal drugs? ____ no _____ yes - how much _________________ how long? ____________

Do you drink caffeine? ____ no _____ yes - how much _________________ how long? ____________

Hospitalizations :

1. Where ______________________________ When __________________ How Long ______
   Reason ____
2. Where ______________________________ When __________________ How Long ______
   Reason ____

Have you ever had any Cardiology testing performed prior to today? YES____ NO____ If so, what was done?

1.____ Where? ______________________________

2.____ Where? ______________________________

Past Medical History: Do you have or have you been treated for:

___ Alcoholism
___ Anemia
___ Anxiety
___Arrhythmias
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Bronchitis
___Cancer
___ Cataracts
___ Congestive Heart Failure
___ CPAP
___ Depression
___ Diabetes
___ Emphysema
___ Fainting
___ Glaucoma
___ Gout
___ Heart Attack
___ Heart Murmurs
___ Hepatitis
___ Hiatal Hernia
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Liver Disease
___ Migraine Headaches
___ Pneumonia
___ Polio
___ Rheumatic Fever
___ Scarlet Fever
___ Sleep Apnea
___ Stroke
___ Thyroid Problems
___ Tuberculosis
___ Ulcers
___ Other (please list) ____

Medications: PLEASE BRING ALL MEDICATIONS WITH YOU TO YOUR VISIT WITH THE DOCTOR

Name of Drug	**Dose (include strength and number of pills per day)**	**How long have you taken this medication?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies (Please describe any reactions to medications):

1.
2.
3.
4.

PATIENT SIGNATURE :______________________________ **DATE:** ____________________