CAMP LOWELL CARDIOLOGY

WELCOME! Please fill out the information below and on the reverse side.

Today's Date _____

Patient's Name_____ Birth Date ___/___/___ Referring Dr._____

Reason for today's visit_____

Location of pain_____ Duration of pain _____

(Where is the pain problem?) *(How long have you had this problem and when did it start?)*

Past Medical History

Do **you** or have **you EVER** had any the following: (Check "**No**" or "**Yes**". Leave blank if uncertain.)

	Yes	No		Yes	No		Yes	No
AIDS or HIV			Coronary Artery Disease, stent			Neurologic Disorder		
Anemia			Deep Vein Thrombosis			Pacemaker		
Aortic Aneurysm			Depression			Palpitations		
Arrhythmia			Diabetes			Peripheral Arterial Disease		
Asthma			GERD/Reflux			Rheumatic Fever		
Atrial Fibrillation			Gastrointestinal Disease			Shortness of breath at rest		
Atrial Flutter			Genitourinary Disease			Shortness of breath when walking		
Bleeding Tendency			Heart Disease			Sleep Apnea		
Blood Clot			Heart Trouble			Sleep Disorder		
Blood/Plasma Transfusions			Hematologic Disease			Stroke		
COPD			Hepatitis			Swelling of feet, ankles or hands		
Cancer			High Cholesterol			TIA		
Cardiomyopathy			Hyperlipidemia			Thyroid Disease		
Carotid Disease			Hypertension			Valvular Abnormalities		
Chest Pain or angina pectoris			Kidney Disease			Valvular Heart Disease		
Congenital Heart Disease			Liver Disease			Warfarin Management		
Congestive Heart Failure			Myocardial Infarction					

List any other medical problems or expand on above if needed:

_____

_____

Please list any other Providers involved in your care:

_____ _____

_____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____

_____

_____

Preferred Pharmacy: _____ **Ph#** _____

Allergies: (Include reaction)

_____

Please list medications, supplements, vitamins or over the counter (list dosages & frequency):_____

_____

_____

_____

_____

Patient Social History **(please circle or fill in the blank below)**

Occupation, if retired what was your last occupation? _____

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: How many drinks do you have per day/week? _____

Use of Tobacco: Never Previously, Quit Date_____ Current, Packs/Day_____

Use of Drugs: Never Current, Type and Frequency_____

Excessive exposure at home or work to: Fumes Solvents Air-borne Particles Noise Animals Dust

Who do you live with? Family? Assisted living? Nursing home? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent, or Guardian_____ Date_____

Provider's Signature:_____ Date _____