



Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin?** **NO** **YES**

Do you have any food, environmental, or drug allergies? **NO** **YES**
(Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? **NO** and Never have **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? **NO** and never have **Socially Only** **Daily** Type: **Beer/ Wine** **Hard Liquor**

Occupation: _____ Hand Dominance: **RIGHT** **LEFT**

Please describe any family health issue(s) below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Do you have a previous cardiologist? **NO** and never have **YES** (Please list below)

Cardiologist Name: _____

Practice Name: _____ Phone: _____

Practice Address: _____

If you have listed a previous Cardiologist, please complete the Authorization for Use and Disclosure of Protected Health Information (PHI).

If you have completed the PHI form, please return this form to the office prior to your appointment so records can be obtained before scheduled appointment with our Cardiologist. If you have any questions please do not hesitate to call our office at (256) 737-2095.



Do you have or have you ever had any of the following:

Symptoms/Illness	NO	Yes, please explain	Symptoms/Illness	NO	Yes, please explain
CONSTITUTIONAL			SKIN		
Fever or chills			Psoriasis/Eczema, etc.		
Weight Loss			Nipple Discharge		
HEMATOLOGIC			Last Menstrual Cycle		Date:
Bleeding Disorders					
HIV/Other Blood Diseases					
ENDOCRINE			NEUROLOGICAL		
Diabetes			CVA		
MUSCULOSKELETAL			Headaches		
Autoimmune			TIA		
Arthritis			GENITOURINARY		
Mobility/Joint Problems			Blood in Urine		
GASTROINTESTINAL			Problems Urinating		
Bleeding ulcers			Prostate Problems		
Diarrhea			Kidney Problems		
Blood in Stool			RESPIRATORY		
Polyps			Asthma		
Liver Problems			COPD		
CARDIOVASCULAR			Respiratory Failure		
Heart Disease			Sleep Apnea		
Deep Vein Thrombosis/DVT			ENT		
Blood Clots in Lungs/Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
Heart Failure			PSYCHIATRIC		
High Cholesterol			Mood Swings		
Stents/Open Heart			Anxiety/Depression		
Pacemaker					
Defibrillator					

Please list any other conditions/ illnesses not indicated above: _____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ **Date:** ____/____/____