HEART & HEALTH INSTITUTE
COMPREHENSIVE CARE EXPERTS

Date:____________________

Patient Name:		Date of Birth:	
MEDICAL HISTORY		**SURGICAL HISTORY**	
Disease/Illness:	**Year diagnosed:**	**Procedure:**	**Mo/Year (ex. 01/2012)**
HOSPITALIZATIONS		**ALLERGIES**	
Reason:	**Mo/Year (ex. 01/2012)**	**Name:**	**Reaction:**
SOCIAL HISTORY			
Do you currently use tobacco? (smoking, chew, etc)	Yes No	Do you drink alcohol?	Yes No
Have you ever used tobacco?	Yes No	If yes, how many times per week do you drink alcohol?	______ /week
If yes, when did you quit? (Year)		If yes, how many drinks do you have per occasion?	______/occasion
FAMILY HISTORY (please list any illnesses your family members have or had. Ex. Breast cancer, diabetes, hypertension, etc.)			
Family member:		**Illness:**	
	Alive Deceased		
	Alive Deceased		
	Alive Deceased		
	Alive Deceased		
	Alive Deceased		

YOUR LAST:	**MM/YY**		**MM/YY**	**FOR WOMEN ONLY**	
Colonoscopy		Flu Shot		Age when periods began:	
Eye Exam		Pneumonia Vaccine		Number of pregnancies:	
Bone Density Test		Tetanus Vaccine		Number of miscarriages:	
PPD test/TB test		Shingles Vaccine		Menopause?	Yes No
Pap Smear		EKG		If yes, at what age?	
Mammogram		Spirometry/PFT		If no, regular periods?	Yes No
				How many days apart?	
Podiatry Visit		Opthamology visit			
Thyroid US		Yearly Exam			

MEDICATIONS: (include name, dose, and frequency. Ex. "Lasix- 40 mg- twice a day"). Use back of page if necessary.	**PHARMACY: (Name and Location)**	**Phone Number:**