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			
Thryoid 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:**