RIVER REGION CARDIOLOGY
HISTORY

Date: _____

Name: _____ DOB: _____ Dr. : _____

Chief complaint or reason for visit today:

_____

_____

Current Medications (please list if you did not bring your meds or a list with you today)

Name	Strength	Dosage	Name	Strength	Dosage

Medical Allergies: _____

_____

Other Allergies: _____

Medical History (past, present including health problems)

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History (list all surgeries)

_____ _____

_____ _____

_____ _____

Hospitalizations

Date	Reason

Family History	If Living		If Deceased	
	Age	Any Health Problems	**Age at Death**	Cause of Death
Father				
Mother				
Brother/Sister 1				
2				
3				
4				
5				

Have your Grandparents, Aunts or Uncles ever had:			
	Circle answer:		Specify whom and maternal or paternal
Cancer	Yes	No	
Tuberculosis	Yes	No	
Diabetes	Yes	No	
Heart Trouble	Yes	No	
High Blood Pressure	Yes	No	
Stroke	Yes	No	
Epilepsy	Yes	No	
Mental Illness	Yes	No	

Social History and Habits:

Do you smoke?	**Do you drink alchohol?**	**Recreational drug use?**
Yes No	Yes No	Yes No
Pack per day _____	Type _____	Circle one
How long _____	How much _____	Past Present
Smoked in the past	How long _____	**Do you exercise?**
Yes No	Used alcohol in your past?	Yes No
How long _____	Yes No	How often_____
	How long _____	Type _____

Do you consume excess caffeine? (more than 3 cups of caffeinated beverages per day)
Yes No

Occupation _____

Hobbies _____

(Office Use Only)

Vital Signs Wgt. _____ Hgt. _____

B/P Right _____ Sitting _____ HR _____

Left _____ Standing _____ HR _____