Medical History Form

Name _____ Date of Birth _____/_____/_____ Today's Date _____/_____/_____

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you!

Present Health Concerns/Reason for Visit

_____

_____

_____

Medications (List all prescription and over-the-counter medications that you are currently taking. Include vitamins, herbal supplements, and medications taken as needed.)

Medication e.g.: Aspirin	**Dosage** e.g.: 81mg	**Frequency** e.g.: once daily	**Prescribing Doctor** e.g.: Dr. Lewis	**Start Date** If known

Allergies ❑ No known drug allergies

Drug/Substance	**Reaction**	**Date of Onset**

Problems

Conditions currently being treated by your physicians	Date of Onset	Physician

Prior Cardiac Testing/Procedures

Test/Procedure	Date Performed	Result
Echo		
EKG		
Cardiac Catheterization		
Carotid Duplex (ultrasound of arteries in the neck)		
ABI/PVR (testing circulation to your legs)		
Stress Test ❑Treadmill Only ❑With Imaging		
Cardiovascular Surgery (specify type)_____		
Other (please specify)_____		
Other (please specify)_____		

History of Present Illness (Check all that apply to your visit today.)

Condition/Symptom	X	Condition/Symptom	X
Coronary Artery Disease		Palpitations	
Chest Pain		Syncope (Fainting)	
Myocardial Infarction (Heart Attack)		Cardiac Arrhythmias	
Coronary Artery Bypass Surgery (CABG)		Stroke or TIA	
Congestive Heart Failure (CHF)		Carotid Artery Disease	
Edema		Peripheral Artery Disease (PAD/PVD)	
Dyspnea (Shortness of Breath)		Heart Valve Disorders	

Risk Factors

Tobacco ❑Never ❑Quit: Date_____ ❑Current Smoker: Packs/day_____ Years used_____

Type of Tobacco: ❑Chew ❑Cigar ❑Cigarettes ❑Pipe ❑Smokeless

Diabetes ❑No ❑Yes: ❑Type 1 or ❑Type 2 Year Diagnosed_____

Dyslipidemia (High Cholesterol) ❑No ❑Yes

Family History of Early CAD (Coronary Artery Disease) ❑No ❑Yes ❑Unknown

Hypertension (High Blood Pressure) ❑No ❑Yes: Year Diagnosed_____

Peripheral Vascular Disease (PVD/PAD) ❑No ❑Yes

Past Medical History (Please include prior illnesses and surgeries not previously mentioned.)

Previous Major Illnesses	Year	Previous Surgeries	Year

Social History

Family

Marital Status_____ ❑Previously Widowed

Children: ❑None #Sons _____ #Daughters _____

Advance directive (Please provide copy of document.)

❑None ❑Do not resuscitate

❑Healthcare proxy ❑Durable power of attorney

❑Do not place on life support ❑Living will

Lifestyle

Type Diet _____

Activity ❑Moderate ❑Sedentary

❑Unable to exercise ❑Vigorous

Type of Exercise _____

Frequency ❑2-3 times/week ❑3-4 times/week

❑daily ❑never ❑occasional

Tobacco

Exposure to second-hand smoke? ❑Yes ❑No

Caffeine

❑Yes ❑No Types _____

Drug use/abuse

❑Never ❑Quit: Date_____

❑Current Type _____

Frequency _____

Route_____

Alcohol

❑Never ❑Quit: Date_____

❑Current

❑Daily ❑Frequently ❑Occasional ❑Rarely ❑Social

Personal

Race _____

Ethnicity _____

Residence ❑Assisted Living ❑Alone ❑Nursing Home

❑With Family Member ❑With Spouse

Primary Language _____

Secondary Language _____

Agree to blood transfusion ❑Yes ❑No

Recent travel ❑Yes ❑No

Education/employment/occupation

Highest level of education _____

Occupation _____

❑Disabled ❑Retired

Exposure to work hazards:

❑anesthestic agents ❑asbestos ❑benzene

❑CRT ❑radiation ❑repetitive hand motion

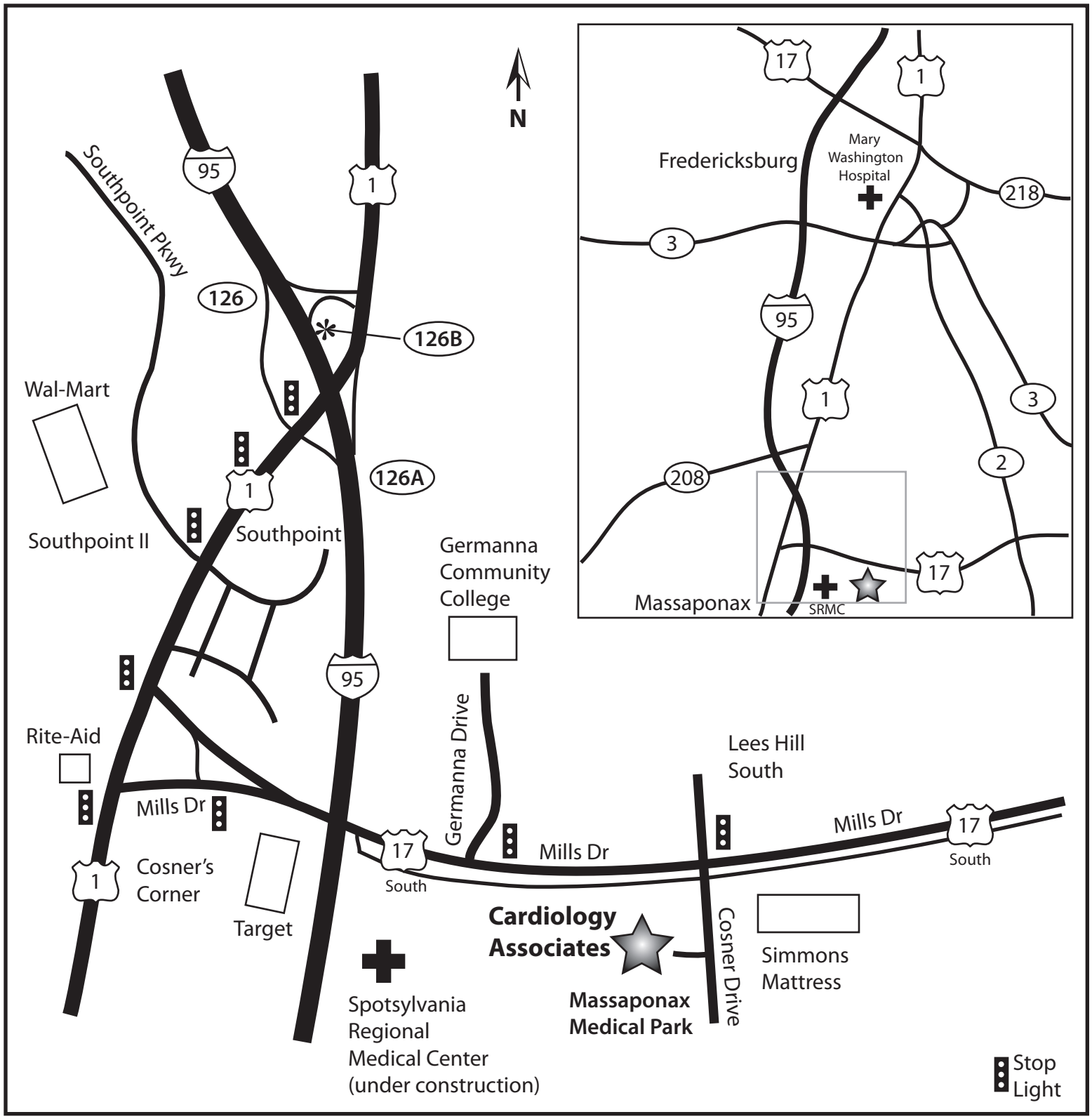
❑solvents ❑TB ❑toxic chemicals ❑toxic fumes

Family History

Member	Age		Medical Conditions (Please check all that apply and circle cause of death.)
Mother		❑Living ❑Deceased	❑Irregular Heart Rhythm ❑Enlarged Heart ❑Congestive Heart Failure ❑Stroke ❑Coronary Artery Disease ❑High Blood Pressure ❑Heart Attack ❑Sudden Death ❑Valvular Heart Disease ❑Diabetes ❑Other_____
Father		❑Living ❑Deceased	❑Irregular Heart Rhythm ❑Enlarged Heart ❑Congestive Heart Failure ❑Stroke ❑Coronary Artery Disease ❑High Blood Pressure ❑Heart Attack ❑Sudden Death ❑Valvular Heart Disease ❑Diabetes ❑Other_____
Sister		❑Living ❑Deceased	❑Irregular Heart Rhythm ❑Enlarged Heart ❑Congestive Heart Failure ❑Stroke ❑Coronary Artery Disease ❑High Blood Pressure ❑Heart Attack ❑Sudden Death ❑Valvular Heart Disease ❑Diabetes ❑Other_____
Brother		❑Living ❑Deceased	❑Irregular Heart Rhythm ❑Enlarged Heart ❑Congestive Heart Failure ❑Stroke ❑Coronary Artery Disease ❑High Blood Pressure ❑Heart Attack ❑Sudden Death ❑Valvular Heart Disease ❑Diabetes ❑Other_____
		❑Living ❑Deceased	❑Irregular Heart Rhythm ❑Enlarged Heart ❑Congestive Heart Failure ❑Stroke ❑Coronary Artery Disease ❑High Blood Pressure ❑Heart Attack ❑Sudden Death ❑Valvular Heart Disease ❑Diabetes ❑Other_____
		❑Living ❑Deceased	❑Irregular Heart Rhythm ❑Enlarged Heart ❑Congestive Heart Failure ❑Stroke ❑Coronary Artery Disease ❑High Blood Pressure ❑Heart Attack ❑Sudden Death ❑Valvular Heart Disease ❑Diabetes ❑Other_____

Review of Symptoms (Please check all of your **current** symptoms.)

Cardiac	❑Chest Pain ❑Palpitations	❑Excessive Sweating ❑Syncope	❑Shortness of breath lying flat ❑Shortness of breath that awakens you at night
Vascular	❑Painful, aching, or tired feeling in legs while walking		❑Swelling of ankles and feet
Constitutional	❑Weight Gain	❑Weight Loss	❑Fever
HEENT	❑Visual Changes	❑Hearing Loss	
Respiratory	❑Snoring	❑Coughing Blood	❑Shortness of Breath
Gastrointestinal	❑Nausea	❑Heartburn	❑Rectal Bleeding/Bloody Stool
Genitourinary	❑Blood in Urine	❑Excessive Nighttime Urination	
Neurological	❑Dizziness	❑Memory Loss	❑Seizures
Psychiatric	❑Depression	❑Hallucinations	
Hematologic	❑Acute Anemia	❑Thrombocytopenia (low platelet count)	
Reproductive	❑Erectile Dysfunction	❑History of Oral Contraception	
Endocrine	❑Goiter	❑Tremors	
Dermatologic	❑Rash	❑Skin Sores	
Musculoskeletal	❑Joint Pain	❑Muscle Pain	



Cardiology Associates of Fredericksburg
Massaponax Medical Park
9530 Cosner Drive, Suite 200
Fredericksburg, VA 22408
(540) 373-1331

From the **East** take **James Madison Pkwy/US-301** south
Turn **right** at **Tidewater Trail/US-17**, continue 18.5 miles
Turn **left** at **Cosner Dr**

From **I-95 North** take exit **126B**
From **I-95 South** take exit **126**
for **US-1 S/US-17 S** toward Massaponax
Merge onto **US-1/US-17**, continue 1.1 miles
Turn **left** at **Mills Dr/US-17**, continue 1.3 miles
Turn **right** at **Cosner Dr** (the third stoplight)

Massaponax Medical Park is on the right just beyond the trees.
Cardiology Associates is located on the second floor of the first building on the right.

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CANCELLATION POLICY

Your appointment time is reserved exclusively for you.

Twenty-four hours notice is required for cancellation of appointments to avoid missed appointment fees:

$25 for Office Visits

$50 for Testing

$150 for Nuclear Stress Tests

Our schedules are consistently full and we need time to fill your vacant slot with another patient from the waiting list. Testing slots are especially difficult to fill on short notice because of required insurance authorizations and regulatory requirements. Additionally, nuclear stress tests require us to purchase a medication specifically for you and your designated appointment time. If we are unable to cancel this medication order, the cost will be billed directly to the patient and is not billable to insurance.

Thank You.