Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination? _____

What is your reason for visit? _____

Symptoms

GENERAL

__Chills
__Depression
__Dizziness
__Fainting
__Fever
__Forgetfulness
__Headache
__Loss of sleep
__Loss of weight
__Nervousness
__Numbness
__Sweats

MUSCLE/JOINT/BONES

Pain, weakness, numbness:
__Arms __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders

GENITO-URINARY

__Blood in urine
__Frequent urination
__Lack of bladder control
__Painful urination

GASTROINTESTINAL

__Appetite poor
__Bloating
__Bowel changes
__Constipation
__Diarrhea
__Excessive hunger
__Excessive thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal bleeding
__Stomach pain
__Vomiting
__Vomiting blood

CARDIOVASCULAR

__Chest pains
__High blood pressure
__Irregular heart beat
__Low blood pressure
__Poor circulation
__Rapid heartbeat
__Swelling of ankles
__Varicose veins

EYE, EAR, NOSE, THROAT

__Bleeding gums
__Blurred vision
__Crossed eyes
__Difficulty swallowing
__Double vision
__Earache
__Ear discharge
__Hay fever
__Loss of hearing
__Hoarseness
__Persistent cough
__Ringing in ears
__Sinus problems
__ Vision – Flashes
__ Vision – Halos

SKIN

__Bruise easily
__Hives
__Itching
__Change in moles
__Rash
__Scars
__Sore that won't heal

MEN only

__Breast lump
__Erection difficulties
__Lump in testicles
__Penis discharge
__Sore on penis
__Other

WOMEN only
__Abnormal Pap Smear
__Bleeding between periods
__Breast lump
__Extreme menstrual pain
__Hot flashes
__Nipple discharge
__Painful intercourse
__Vaginal discharge
__Other
Date of last menstrual period_____
Date of last pap smear_____
Have you ever had a mammogram?_____
Are you pregnant? _____
Number of children? _____

Conditions

__Aids
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Bleeding Disorders
__Breast Lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herpes
__High cholesterol
__HIV Positive
__Kidney Disease
__Liver Disease
__Measles
__Migraine headaches
__Miscarriage
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Pacemaker
__Pneumonia
__Polio
__Prostate Problems
__Psychiatric Care
__Rheumatic Fever
__Scarlet Fever
__Stroke
__Suicide Attempt
__Thyroid Problems
__Tonsillitis
__Tuberculosis
__Thyroid Fever
__Ulcers
__Vaginal Infections
__Venereal Disease

Medications

_____ _____ _____
_____ _____ _____
_____ _____ _____

Pharmacy Name_____ Phone_____

Allergies

_____
_____
_____
_____

Health History

ASSOCIATES IN
CARDIOVASCULAR CARE, P.A.
1061 AVENUE C
BAYONNE, NEW JERSEY 07002

Relation	Age	State of Health	Age at Death	Cause of Death	Check (X) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (X) which substance you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximately dates _____

Serious Illness/Injuries	Date	Outcome

Occupational

Check (X) which substance you use and describe how much you use.

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed by Date