Name: ______________________________ DOB: ______________________________

Primary Care Physician: ______________________________ Pharmacy: ______________________________

Please give front desk a list of your medications or fill in the medications here:

Medication	Strength (i.e., mg)	Directions (i.e., once a day)

Drug Allergies: ______________________________

Surgeries:

____

____

____

____

Personal History:

Diabetes: Y N	Stroke: Y N	Pacemaker: Y N
High Cholesterol: Y N	Blocked Arteries: Y N	Stent: Y N
Heart Attack: Y N	High Blood Pressure: Y N	Arrhythmia: Y N

Other Illnesses: ______________________________

Family History of Heart Disease? Y N Who? ______________________________

Do you have a living will/ advanced directive? Y N

Social History:

Tobacco use:	Never	Former	Current (How many per day? ______________)		
Alcohol use:	Never	Occasional	Moderate	Heavy	
Exercise:	None	Occasional	Moderate	Heavy	
Marital Status:	Single	Married	Separated	Divorced	Widowed

Occupation: ______________________________