**Washington Metropolitan Cardiology**

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Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Male \_\_\_\_\_ Female

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Single \_\_\_\_\_ Married

 \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced

City/Town \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL MEDICAL HISTORY**

PRIMARY CARE DOCTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY/ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR TODAY’S VISIT:**

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***Please check if you have or have ever had the following***:

\_\_\_­ Abnormal EKG \_\_\_­ Heart Attack

\_\_\_­ Abnormal Stress Test \_\_\_­ High Blood Pressure

\_\_\_­ Atrial Fibrillation \_\_\_­ High Cholesterol

\_\_\_ ­Cardiomyopathy \_\_\_­ Hypotension

\_\_\_­ Chest Pain \_\_\_­ Kidney Disease

\_\_\_­ Congestive Heart Failure \_\_\_­ Palpitations

\_\_\_­ Coronary Artery Disease \_\_\_­ Shortness of Breath

\_\_\_­ Diabetes \_\_\_­ Stroke

 \_\_\_­ Edema/Leg Swelling \_\_\_­ Thyroid Disease

***Any other medical issues***:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you had any recent hospitalizations?** If so, please list reason with related dates:

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**MEDICATIONS YOU ARE CURRENTLY TAKING (include dosage and frequency):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DRUG ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOOD ALLERGIES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please check if you have a family history of the following: Please list your relationship of family member with this issue.***

\_\_\_\_\_\_\_\_\_\_\_ Heart Attack \_\_\_\_\_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol \_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_ Diabetes

**Smoking**: \_\_\_\_\_ Never \_\_\_\_\_ Former \_\_\_\_\_ Current

*If former smoker, how long has it been since you last smoked?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If current smoker, how many cigarettes per day?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol:** \_\_\_\_\_ Never \_\_\_\_\_ Rarely \_\_\_\_\_ Occasionally \_\_\_\_\_ Socially

 \_\_\_\_\_ Yes

*If yes, how many drinks per week?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any caffeine use? How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? If so, how much and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_­­­­­\_\_