Cardiovascular Specialists of New England

MEDICAL INFORMATION

Name:_____DOB_____Age_____Date:_____
Reason for coming to the office _____
Primary Care Physician? _____ Referred by _____
Do you have a Living Will? Yes ☐ No ☐ Current Occupation _____

Medical/Family History

Do you have any Allergies to medications? Yes ☐ No ☐ ____If yes, please list medication and reaction.

_____

Are you allergic to Contrast Dye? Yes ☐ No ☐
Current Medications, Dosages and Frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Have you been diagnosed with the following?

1. Diabetes Yes ☐ No ☐ Insulin dependent Yes ☐ No ☐
2. High Blood Pressure Yes ☐ No ☐
3. Elevated Cholesterol/Triglycerides Yes ☐ No ☐
4. Family History with heart disease before age 65? Yes ☐ No ☐
   If Yes (Please Circle: father, mother, sister, brother, aunt, uncle)
   Please Circle: Heart Attack, Stroke, Mini Stroke, Coronary Artery Disease, Carotid Disease, Valve Disease, Vascular Disease
5. List all other Family History: Who/What:
   _____
6. Do you have a Pacemaker/ICD/Loop Recorder Implant? Yes ☐ No ☐ If yes, Company _____
   Date Implant _____ Hospital Name _____
7. List Hospitalizations/Surgeries include Year and Hospital name:
   1. _____
   2. _____
   3. _____
   4. _____
8. List all medical problems:
   _____

Social History

Have you ever used tobacco? Yes ☐ No ☐ Type _____
Smoking status? --> Former ☐ Date quit _____ Current ☐ Pack per day _____
Alcoholic beverages? Yes ☐ No ☐ If yes, number/day _____ Number/week _____
Caffeinated beverages? (Soda, tea, coffee, energy drinks, Including decaf) Yes ☐ No ☐
number/day _____ number/week _____
History of Drug Abuse? Yes ☐ No ☐ Drug Used _____

Signature _____ Date _____