RGG
RIHNER, GUPTA & GROSZ
CARDIOLOGY, P.C.

NEW PATIENT HISTORY

Name: _____ **Date:** _____
(Last) (First) (Middle)

Date of Birth: _____ **Age:** _____ **Primary Care Physician:** _____

MEDICATIONS

Do you have any medication allergies? No___ Yes, please list medication(s) with type of reaction:

_____

PRESCRIPTION MEDICATIONS

MEDICATION	DOSE (mg.)	FREQUENCY	MEDICATION	DOSE (mg.)	FREQUENCY
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

Please indicate if you have any of the following:

Chest pain	No	Yes, for how long _____		
Shortness of breath	No	Yes, for how long _____		
Palpitations	No	Yes, for how long _____		
Dizziness	No	Yes, for how long _____		
Passing out spells	No	Yes, last spell _____		
Swelling in the legs	No	Yes, for how long _____		
High blood pressure	No	Yes, for how long _____		
High cholesterol	No	Yes		
Diabetes	No	Yes		
Coronary artery disease	No	Yes		
Heart stent	No	Yes, last stent_____		
Previous heart bypass surgery	No	Yes, Date_____, Hospital _____		
Leg circulation Problems	No	Yes, previous leg stent/bypass	Yes	No
Carotid artery blockage	No	Yes, previous stent/surgery	Yes	No
Abdominal aortic artery aneurysm	No	Yes, previous stent/surgery	Yes	No
Previous stroke	No	Yes, year of stroke _____		
Congestive heart failure	No	Yes, any recent admissions	Yes	No
Pacemaker/Defibrillator	No	Yes, year of insertion _____		
Leaky/narrowed heart valve	No	Yes, previous heart valve surgery	Yes	No
Heart ablation in the past	No	Yes, year of ablation _____, type of ablation if known _____		

Please circle if you have any of the following:

General:	Thyroid	Adrenal	Gout	Glaucoma	Arthritis	Fatigue
Lung:	Asthma	COPD	Lung Cancer			
Stomach:	Peptic Ulcer Cirrhosis	Heartburn Fatty Liver	Gerd Colitis	Gall Bladder Crohn's Disease	Liver Disease	
Kidney:	Dialysis	Urinary Problems	Enlarged Prostate			
Blood:	Anemia	Bleeding Disorders				
Gynecological:	Post Menopausal	Hysterectomy	Hormone replacement			
Other:	Cancer (please list type) _____		HIV/AIDS			

Other Medical Problems/Concerns you may have:

_____

SURGERY/HOSPITALIZATION (Please list below)

_____

_____

PERSONAL HISTORY

Occupation: _____ Marital Status: _____ Children: _____

Do you smoke? ***Yes*** _____ For how long (yrs)? _____ How often (packs/day)? _____

Quit _____ When (yrs) ? _____ How long DID you smoke for (yrs) ? _____

Never _____

Do you consume alcoholic beverages?

No _____ ***1-3 drink/wk*** _____ ***3-10 drinks/week*** _____ >***10 drinks/week*** _____

Do you, or have you used, illegal drugs?

No _____ ***Yes*** _____ Date last used? _____

Do you, or have you used, intravenous drugs?

No _____ ***Yes*** _____ Date last used? _____

Do you exercise regularly?

No _____ ***Yes*** _____ How long? _____ How often? _____

How much caffeine do you consume daily? How many? _____ How often? _____

Do you have a living will or an advance directive? ***Yes*** _____ ***No***_____

FAMILY HISTORY

Have any of your family members had any of the following problems?

Please use M (Mother), F (Father), GM (Grandmother), GF (Grandfather), S (Sister), B (Brother), C (Children)

PROBLEM	FAMILY MEMBER/MEMBERS AND AGE OF ONSET FOR EACH
Stroke	
Heart Attack	
Heart Bypass	
Angioplasty/Stent	
Diabetes	
High Blood Pressure	
Cholesterol/Triglycerides	
Leg Circulation Problems	
Carotid (Neck) Blockage	
Pacemaker	

Please add any pertinent family history:

_____

_____