Robert Wood Johnson Physician Enterprise- Heart Specialists of Central Jersey, LLP

MEDICAL HISTORY FORM

Patient Name: _____**Date**:_____
Date of Birth: _____ **Age**: _____ **Sex:** _____
Primary Care Physician: _____**Referring Physician:** _____
E-mail: _____
Reason for today's visit: _____

Do you have any chest discomfort? Yes No
If yes, how long does it last? _____ What brings it on? _____
Is it associated with: __Shortness of breath __Deep Breaths __Sweats __Lightheadedness
__Palpitations __Nausea __Changes in position

Cardiac Risk Factors

History of Heart Disease	Yes	No
History of High Blood Pressure	Yes	No
History of Diabetes	Yes	No
History of High Cholesterol	Yes	No
History of Peripheral Vascular Disease	Yes	No

____Heart attack	Date/Facility_____
____Cardiac Cath	Date/Facility_____
____PCI/Angioplasty	Date/Facility_____
____Bypass surgery	Date/Facility_____
____Pacemaker	Date/Facility_____
___Automatic Defibrillator	Date/Facility_____

Medications (list doses and frequency)

_____
_____
_____

Do you have any drug allergies? Yes No (If yes, please list below)

_____
_____

Surgical History (list surgery and date of surgery)

_____
_____

Social History

___Married ____Single ____Widowed ____Children Occupation_____
Tobacco (including chewing tobacco/vape/e-cigarettes)
____Never
____Former Age start/#of years_____ Amount per day_____
____Current Age start/#of years_____ Amount per day_____
Caffeine____ How much_____
Alcohol_____ Former_____ Current_____ Amount per day_____
Other substance use (including marijuana, cocaine, other illicit drugs_____

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Family History

Age **If Any Illnesses** **If deceased, cause of death**

Mother _____
Father _____
Siblings_____
_____
_____
_____
Children _____
_____

REVIEW OF SYSTEMS/PLEASE CIRCLE YES OR NO

Palpitations	Yes	No	Diarrhea	Yes	No
Dizziness	Yes	No	Constipation	Yes	No
Black outs	Yes	No	Blood in stool	Yes	No
Pains in legs with walking	Yes	No	Ulcer disease	Yes	No
Short of breath (SOB)	Yes	No	Colon cancer	Yes	No
Unable to sleep due to SOB	Yes	No	Colon polyps	Yes	No
Swollen feet	Yes	No	Increased urinary frequency	Yes	No
Need more than 2 pillows to sleep	Yes	No	Blood in urine	Yes	No
History of heart murmur	Yes	No	Kidney stones	Yes	No
History Rheumatic fever	Yes	No	Urinary infections	Yes	No
History of pericarditis	Yes	No	Sexual problems	Yes	No
History of heart rhythm problems	Yes	No	Last menstrual cycle, date:		
Sleep apnea	Yes	No	Joint pains	Yes	No
Loud snoring	Yes	No	Osteoarthritis	Yes	No
Fevers	Yes	No	Osteoporosis	Yes	No
Recent change in weight	Yes	No	Weakness or stiffness	Yes	No
Headaches	Yes	No	Rashes	Yes	No
Visual changes	Yes	No	Skin cancer	Yes	No
Glaucoma	Yes	No	Loss of hair	Yes	No
Double vision	Yes	No	Thyroid problems	Yes	No
Hearing loss	Yes	No	Excessive thirst or urination	Yes	No
Ringing in the ears	Yes	No	Heat or cold intolerance	Yes	No
Sinus problems	Yes	No	Skin dryness	Yes	No
Nose bleeds	Yes	No	Seizures	Yes	No
Sore throat/changes in voice	Yes	No	Numbness or tingling	Yes	No
Cough	Yes	No	Varicose veins	Yes	No
Sputum	Yes	No	Phlebitis	Yes	No
Coughing up blood	Yes	No	Cancer	Yes	No
Emphysema	Yes	No	Anemia	Yes	No
Asthma	Yes	No	Enlarged glands	Yes	No
Loss of appetite	Yes	No	Bleeding problems	Yes	No
Abnominal pain	Yes	No	Depression	Yes	No
Heart burn	Yes	No	Memory loss or confusion	Yes	No
Change in bowel habits	Yes	No	Insomnia	Yes	No