

# Bellevue Cardiology

## NEW PATIENT HEALTH HISTORY FORM

**Patient Name:** \_\_\_\_\_ **Birth date:** \_\_\_/\_\_\_/\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Referring Physician:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

**Please describe this problem:** \_\_\_\_\_

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Pradaxa, Xarelto, Eliquis, Brilinta, Vitamin E, Plavix, Coumadin, or Aspirin?**  **NO**  **YES**

Do you have any food, environmental, or drug allergies?  **NO**  **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke?  **NO** and Never have  **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol?  **NO** and Never have  **Socially Only**  **Daily**  **Beer/ Wine**  **Hard Liquor**

Occupation: \_\_\_\_\_ Hand Dominance:  **RIGHT**  **LEFT**

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Patient Name: \_\_\_\_\_

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
<b>Constitutional</b>			<b>Skin</b>		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
<b>Hematologic</b>			<b>Last Mammogram</b> Date: ___/___/___		
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
<b>Endocrine</b>			History of Keloids		
Thyroid Problems			<b>Neurological</b>		
Diabetes			Neurological Problems		
<b>Musculoskeletal</b>			Headaches		
Arthritis			<b>GENITOURINARY</b>		
Mobility/ Joint Problems			Genital or Oral Herpes		
<b>GASTROINTESTINAL</b>			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
<b>CARDIOVASCULAR</b>			<b>Eyes</b>		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/ DVT			<b>ENT</b>		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
<b>RESPIRATORY</b>			<b>PSYCHIATRIC</b>		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: \_\_\_\_\_

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Physician Signature: \_\_\_\_\_ Date Reviewed: \_\_\_/\_\_\_/\_\_\_