CAROLINA HEART SPECIALISTS, LLC

PAST, FAMILY AND SOCIAL HISTORY

ID # _____

NAME: _____ D.O.B.____/____/____ TODAY'S DATE____/____/____

REASON FOR TODAY'S VISIT: _____

WHO IS YOUR CURRENT FAMILY DOCTOR? _____

PAST MEDICAL HISTORY *(Please indicate Yes or No. Give an explanation below for all "Yes" answers.)*

High Blood Pressure	[ ] Yes [ ] No	Early Menopause	[ ] Yes [ ] No
Low Blood Pressure	[ ] Yes [ ] No	Cancer	[ ] Yes [ ] No
Angina (Chest Pain)	[ ] Yes [ ] No	Stroke	[ ] Yes [ ] No
High Cholesterol	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No
Heart Attack	[ ] Yes [ ] No	Arthritis	[ ] Yes [ ] No
Rheumatic Fever	[ ] Yes [ ] No	Circulatory Problems	[ ] Yes [ ] No
Artificial Heart Valves	[ ] Yes [ ] No	AIDS or other	
Artificial Joints	[ ] Yes [ ] No	Immunosuppresive Disorder	[ ] Yes [ ] No
Recent Weight Loss	[ ] Yes [ ] No	Jaundice or Liver Disease	[ ] Yes [ ] No
Diabetes	[ ] Yes [ ] No	Special Diet	[ ] Yes [ ] No
Respiratory Disease	[ ] Yes [ ] No	Psychiatric Care	[ ] Yes [ ] No

_____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medications? [ ] Yes [ ] No
If so, what? _____

PREVIOUS HEART RELATED TESTS OR PROCEDURES *(Please indicate Yes or No)*

Echo	[ ] Yes [ ] No	Date____/____/____	Where performed? _____
Stress Test	[ ] Yes [ ] No	Date____/____/____	Where performed? _____
Heart Cath	[ ] Yes [ ] No	Date____/____/____	Where performed? _____
Bypass Surgery	[ ] Yes [ ] No	Date____/____/____	Where performed? _____
Other	[ ] Yes [ ] No	Please describe	_____

FAMILY HISTORY

Family history of heart disease: [ ] father age at onset _____
[ ] mother age at onset _____
[ ] siblings age at onset _____ _____ _____

SOCIAL HISTORY

Marital Status: [ ] single [ ] married [ ] divorced [ ] separated [ ] spouse deceased

Occupation_____ Heavy physical activity required? [ ] Yes [ ] No
[ ] Retired

Tobacco Use	[ ] Yes [ ] No	_____# of packs per day _____# years smoked Date quit____/____/____
Alcohol Use	[ ] Yes [ ] No	type_____amount_____
Drug Use	[ ] Yes [ ] No	type_____
Diet Pills	[ ] Yes [ ] No	Describe brand and duration of use_____

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____