BARON CARDIOLOGY GROUP, P.C.

MEDICAL HISTORY

Name _____ Date _____

Allergies

☐ None
☐ Latex
☐ Iodine
☐ Tape If yes, type: _____
☐ Foods If yes, name of food(s): _____

☐ Antibiotics If yes, type:_____
☐ Pain Medications If yes, type: _____
☐ Other Medications If yes, type: _____
☐ Other Allergies List: _____
_____

Surgical History

	Date:	Name of Surgeon:
☐ Tonsils	_____	_____
☐ Gallbladder	_____	_____
☐ Appendix	_____	_____
☐ Coronary Artery Bypass	_____	_____
☐ Heart Stent(s)	_____	_____
☐ Valve Replacement(s)	_____	_____
☐ Permanent Pacemaker	_____	_____
☐ Internal Cardioverter Defibrillator	_____	_____
☐ Ablation of Rhythm	_____	_____
☐ Kidney Removal	_____	_____
☐ Cataracts	_____	_____
☐ Other	_____	_____

Describe: _____

Medical History

	Date of diagnosis:		Date of diagnosis:
☐ High blood pressure	_____	☐ Congestive Heart Failure	_____
☐ Kidney stones	_____	☐ Palpitations	_____
☐ Diabetes	_____	☐ Depression	_____
☐ COPD/Emphysema	_____	☐ Liver Disease	_____
☐ Stroke	_____	☐ Alcoholism	_____
☐ Anemia	_____	☐ Ulcers	_____
☐ Arthritis	_____	☐ Epilepsy	_____
☐ Asthma	_____	☐ Eye problems/glaucoma	_____
☐ Thyroid Disease	_____	☐ Other	_____
☐ Cancer	_____		

Type: _____ Describe: _____
_____

Social History

Marital Status: _____ Occupation: _____

Do you smoke?

☐ No, I have never smoked
☐ No, but I previously smoked
Date quit: _____ Number of years you smoked before quitting: _____
☐ Yes, I am currently a smoker
Number of packs per day: _____ Number of years you have smoked: _____

How many alcoholic drinks do you have per week? ☐ None ☐ 1 or less ☐ 2 or 3 ☐ 4 to 6 ☐ 7 to10 ☐ 11 to 14 ☐ 15 or more

Have you ever had a blood transfusion? ☐ Yes ☐ No

How many caffeinated beverages do you have per day? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Family History

If yes, relationship to you (e.g., mother, father, sibling, etc.):

☐ High blood pressure _____
☐ Diabetes _____
☐ Heart disease _____
Describe: _____

Current Symptoms (check all that apply)

☐ Fever	☐ Chest pains	☐ Chronic back pain	☐ Abnormal bleeding	☐ Rash
☐ Weight loss	☐ Irregular heart beat	☐ Chronic neck pain	☐ Fatigue	☐ Headaches
☐ Chills	☐ Shortness of breath	☐ Sore muscles	☐ Weakness	☐ Cataracts
☐ Blurry vision	☐ Wheezing	☐ Dizziness	☐ Abdominal pain/nausea	☐ Incontinence
☐ Double vision	☐ Chronic cough	☐ Persistent itching	☐ Swollen ankles	
☐ Nasal stuffiness	☐ Painful urination	☐ Numbness	☐ Swollen glands	
☐ Sore throat	☐ Blood in urine	☐ Tingling	☐ Hearing loss	

Hospitalizations

Reason for admission	Date of admission	Name of hospital

Current Medications (include prescription medications, over-the-counter medications, vitamins, calcium, and herbal supplements)

Name of drug	Dosage	How often taken

Current Health Care Providers and Suppliers (list all providers from whom you currently receive care/treatment)

Name of Provider	Specialty	Condition Treated	Date Treatment Began