CAMP LOWELL CARDIOLOGY

WELCOME! Please fill out the information below and on the reverse side.

Today's Date _____

Patient's Name_____ Birth Date ___/___/___ Referring Dr._____

Reason for today's visit_____

Location of pain_____ Duration of pain _____

(Where is the pain problem?) *(How long have you had this problem and when did it start?)*

Past Medical History

Have you EVER had the following: (Check "**No**" or "**Yes**". Leave blank if uncertain.)

	Yes	No		Yes	No		Yes	No
Measles			Bladder Infections			Hemorrhoids		
Mumps			Epilepsy			Asthma		
Chickenpox			Migraine Headaches			Hives or Eczema		
Whooping Cough			Tuberculosis			AIDS or HIV		
Scarlet Fever			Diabetes			Infectious Mono		
Diphtheria			Cancer			Bronchitis		
Smallpox			Polio			Mitral Valve Prolapse		
Pneumonia			Glaucoma			Stroke		
Rheumatic Fever			Hernia			Hepatitis		
Heart Disease			Blood/Plasma Transfusions			Ulcers		
Arthritis			Back Trouble			Kidney Disease		
Venereal Disease			High Blood Pressure			Thyroid Disease		
Anemia			Low Blood Pressure			Bleeding Tendency		

Review of Cardiovascular System (please circle the following):

Heart trouble……yes no Chest pain or angina pectoris…..yes no Shortness of breath when walking… yes no

Palpitations……yes no Swelling of feet, ankles or hands…. yes no Shortness of breath at rest…… yes no

Date of last chest x-ray:_____

List any other medical problems:_____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____

_____

_____

Medication Allergies

_____

Medications, including over the counter:_____

_____

_____

_____

_____

Preferred Pharmacy: _____ **Ph#** _____

***Patient Social History* (please circle below)**

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously, Quit Date_____		Current, Packs/Day_____	
Use of Drugs:	Never	Current, Type and Frequency_____			
Excessive exposure at home or work to:	Fumes	Solvents	Air-borne Particles	Noise	Animals
	Dust				

Family Medical History

	Age	Diseases	If Deceased, cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent, or Guardian_____ Date_____

Provider's Review:

Provider's Signature:_____Date_____