USF DEPARTMENT CARDIOLOGY NEW PATIENT INTAKE FORMS

Name _____ Date _____

Date of Birth _____ Age _____ Occupation _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Widower / Widow

Birth Place _____ Education Level _____

Physician referrin for Cardiac assessment: _____

Have you seen a Cardiologist (heart doctor) before _____Yes _____ No
If yes, please ask them to fax your records to our office or bring your records with you.

Do you have a pacemaker or other cardiac device? _____ Yes _____ No

What brand ? _____(Medtronic / St Jude / Guidant / Boston Scientific)
Please bring card to appointment.

Have you had any cardiac surgery or procedure (ablation, etc)? _____ Yes _____ No

What type of procedure and when? _____

_____

_____

Patientis Social History

Do you work ? _____ Yes _____ No _____ Retired If yes, what do you do? _____

Do you currently use or have previously used illicit drugs? _____ Yes _____ No

If yes, how much, what type and how often? _____

Do you currently use or have previously used (smoke or chew) tobacco ? _____ Yes _____ No

If yes:

Cigarettes	____ Yes	____ No	____ pack/day for	____ years	Date stopped _____
Cigars	____ Yes	____ No	____ per day for	____ years	Date stopped _____
Pipe	____ Yes	____ No		____ years	Date stopped _____
Chewing	____ Yes	____ No		____ years	Date stopped _____
Snuff	____ Yes	____ No		____ years	Date stopped _____

Do you now or have you or have you ever consumed alcohol? ____ Yes ____ No

If yes, how much and how often? _____

PREVIOUS SURGERIES:

Type of Surgery	Place	Date

ALLERGIES:

Drug or other	Reactions	

MAJOR ILLNESS OR INJURIES:

Reason for Admission	Place	Date

HABITS:

List below all medications, vitamins, laxatives, etc., that you have taken regularly during the past month. If the name of the medications is not known, please find the name from your pharmacist. Bring all medications with you.

Name (if known)	Purpose Taken	How often taken If daily how many per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Mother:

If living: Her age _____ years

History of heart disease: _____ Yes _____ No

If yes: What age diagnosed: _____

Health: _____

If deceased: Age at death _____ years

Cause: _____

Father:

If living: His age _____ years

History of heart disease: _____ Yes _____ No

If yes: What age diagnosed: _____

Health: _____

If deceased: Age at death _____ years

Cause: _____

Living: Brother or Sister

Age _____ Sex _____ Health _____
Heart Disease _____ Yes _____ No What age diagnosed? _____

Age _____ Sex _____ Health _____
Heart Disease _____ Yes _____ No What age diagnosed? _____

Age _____ Sex _____ Health _____
Heart Disease _____ Yes _____ No What age diagnosed? _____

Age _____ Sex _____ Health _____
Heart Disease _____ Yes _____ No What age diagnosed? _____

Do you have problems with any of the following? (If YES, please give a brief description)

____ Syncope (fainting spells) _____

____ Indigestion _____

____ Cough _____

____ Weigh Change _____

____ Headaches _____

____ Nervousness _____

____ Eyes, Ears, Nose, and Throat _____

____ Other _____

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date