

S O U T H D E N V E R C A R D I O L O G Y A S S O C I A T E S , P . C .

Today's Date: _____

PATIENT INFORMATION DATA (please print)

Social Security #: _____

Name: _____ Date of Birth: _____ Gender (circle one) F M

Address: _____ City: _____ Zip Code: _____

Home phone #: _____ Work phone #: _____ E-mail: _____

Reason for today's visit: _____

Referring physician and all physicians to send report of visit: _____

PAST MEDICAL AND SURGICAL HISTORY (Please circle and explain)

Heart attacks, angioplasties, angina: _____

Heart Valve disease _____ Heart rhythm abnormalities _____

Congestive Heart Failure _____ Heart surgery _____

Smoke ever? YES NO Packs per day _____ Years smoking _____ Currently smoke? YES NO Year quit _____

Diabetes? YES NO Duration _____ High blood pressure? YES NO

High Cholesterol? YES NO

Asthma or emphysema _____ Rheumatic Fever _____ Strokes/TIAs _____

Other significant illnesses _____

Surgeries _____

SOCIAL HISTORY

Occupation: _____

Marital Status (circle) Single Married Divorced Widowed Separated

Alcoholic drinks (average per week) _____ Street drug use? YES NO Caffeinated drinks a day _____

ALLERGIES

Medication allergies _____

Have you ever had X-ray dye? YES NO Any reaction to x-ray dye, iodine, or shellfish? _____

