BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
CARDIOLOGY PRACTICE

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

Name: ______________________
ID #: ______________________
Date: ______________________

Reason for visit: ____
____
____
____

Medications: ____________________________
____
____
____

Allergies: ____________________
____

Medical History:

- **Patient medical history:**

Diabetes	Y	N	COPD	Y	N
Hypertension	Y	N	Bleeding tendency	Y	N
Stroke	Y	N	Acute infections	Y	N
Heart trouble	Y	N	Poor circulation	Y	N
Cholesterol	Y	N	Hereditary defects	Y	N
Emphysema	Y	N			

If yes, explain: ____
____
____

Previous Hospitalizations/Surgeries/Serious Injuries — When?
____
____
____
____

- **Patient social history:**

Marital status: Single: ____ Married: ____ Separated: ____ Divorced: ____ Widowed: ______
Use of alcohol: Never: ____ Rarely: ____ Moderate: ____ Daily: _____
Use of tobacco: Never: ____ Quit Smoking: __ Current packs per day: _____
Use of drugs: Never: ____ Type/Frequency: ______________________________
Excessive exposure at home or work to: Fumes: ____ Dust: ____ Solvents: _______ Air-borne particles: ____ Noise: _______

Occupation/Work: ____

- **Family medical history:**

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please circle if you are experiencing any of the following:

- *CONSTITUTIONAL SYMPTOMS*
  - Good General healthy lately ____ Yes No
  - Recent weight change ____ Yes No
  - Decreased appetite ____ Yes No
  - Fever/night sweats ____ Yes No
  - Fever/night sweats ____ Yes No
  - Headaches ____ Yes No
- *EYES*
  - Eye disease or injury ____ Yes No
  - Wear glasses/contact lenses ____ Yes No
  - Vision problems ____ Yes No
  - Glaucoma/cataracts ____ Yes No
- *EARS/NOSE/THROAT*
  - Chronic sinus problems of rhinitis ____ Yes No
  - Nose bleeds/mouth sores ____ Yes No
  - Sore throat or voice change/swollen glands ____ Yes No
  - Problems with hearing ____ Yes No
- *CARDIOVASCULAR*
  - Heart trouble ____ Yes No
  - Chest pain or angina pectoris ____ Yes No
  - Palpitations ____ Yes No
  - Shortness of breath with walking or lying flat ____ Yes No
  - Swelling of feet, ankles or hands ____ Yes No
  - Fast/slow heart beat ____ Yes No
  - Peripheral vascular disease ____ Yes No
- *RESPIRATORY*
  - Chronic or frequent coughs ____ Yes No
  - Spitting up blood ____ Yes No
  - Shortness of breath ____ Yes No
  - Asthma or wheezing ____ Yes No
  - Snoring ____ Yes No
- *GASTOINTESTINAL*
  - Loss of appetite ____ Yes No
  - Change in bowel habits ____ Yes No
  - Nausea or vomiting ____ Yes No
  - Frequent diarrhea/constipation ____ Yes No
  - Rectal bleeding or blood in stool ____ Yes No
  - Abdominal pain ____ Yes No
  - Peptic ulcer (stomach or duodenal) ____ Yes No
- *GENITOURINARY*
  - Problems with urination ____ Yes No
  - Kidney stones ____ Yes No
  - Sexual difficulty ____ Yes No
  - Male – testicle pain/lumps ____ Yes No
  - Prostate problems ____ Yes No
  - Female-irregular periods ____ Yes No
  - Estrogen replacement ____ Yes No
  - Hysterectomy ____ Yes No
  - Late menstrual periods ____ Yes No

Reviewed by: ____

Date: ____

- *MUSCULOSKELETAL*
  - Joint pain ____ Yes No
  - Joint stiffness or swelling ____ Yes No
  - Weakness of muscles or joints ____ Yes No
  - Muscle pain or cramps ____ Yes No
  - Back pain ____ Yes No
  - Difficult/pain in walking ____ Yes No
- *INTEGUMENTARY (skin, breast)*
  - Rash or itching ____ Yes No
  - Change in skin color ____ Yes No
  - Change in hair or nails ____ Yes No
  - Varicose veins ____ Yes No
  - Breast pain ____ Yes No
  - Breast lump ____ Yes No
  - Breast discharge ____ Yes No
- *NEUROLOGICAL*
  - Frequent or recurring headaches ____ Yes No
  - Light-headed or dizzy ____ Yes No
  - Convulsions or seizures ____ Yes No
  - Numbness/tingling sensations ____ Yes No
  - Tremors ____ Yes No
  - Paralysis ____ Yes No
  - Stroke ____ Yes No
  - Head Injury ____ Yes No
- *PSYCHIATRIC*
  - Memory loss or confusion ____ Yes No
  - Nervousness ____ Yes No
  - Depression ____ Yes No
  - Insomnia ____ Yes No
- *ENDOCRINE*
  - Glandular/hormone problem ____ Yes No
  - Thyroid disease ____ Yes No
  - Heat or cold intolerance ____ Yes No
  - Diabetes (insulin or non insulin, circle one) Yes No
  - Excessive thirst or urination ____ Yes No
- *HEMATOLOGIC/LYMPHATIC*
  - Bleeding or bruising tendency ____ Yes No
  - Slow to heal after cuts ____ Yes No
  - Anemia ____ Yes No
  - Phlebitis ____ Yes No
  - Past transfusion ____ Yes No
- *ALLERGIC/IMMUNOLOGIC*
  - History of skin or other adverse reaction to:
  - Penicillin or other antibiotics ____ Yes No
  - Morphine, Demerol, other narcotics ____ Yes No
  - Novocaine, other anesthetics ____ Yes No
  - Aspirin, other pain remedies ____ Yes No
  - Tetanus antitoxin, other serums ____ Yes No
  - Iodine, merthiolate, other antiseptic ____ Yes No
  - Other drugs/medications: ____

Known food allergies: ____

Environmental allergies: ____