



Heart Specialists of Lancaster P.C.

Today's Date: _____ Family Doctor: _____
 Name: _____
 Age: _____ Date of Birth: _____
 Medication Allergies: _____
 Pharmacy: _____

Past Medical History – Indicate whether you have had any of the following conditions in the past.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Bladder disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Abnormal chest x-ray | <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Joint disease | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach disorder | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Vein disorder/blood clots | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bowel disorder | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Anemia low blood count | | | |

Past Surgical History - _____

Family History – Check each item that applies. ADOPTED or no family history available _____

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol Abuse								
Asthma								
Cancer – Breast								
Cancer								
Cancer – Prostate								
Coronary Heart Disease								
Dementia								
Depression								
Type 2 Diabetes								
Hypertension								
Osteoporosis								
Stroke								
Thyroid Disease								

Family Status – Enter age of death.

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alive								
Deceased								
Unknown								
Other								

Social Status

Tobacco Use:
 Never
 Yes _____ Packs per day
 Quit _____ Date Quit _____ Years Quit
Type (Circle One): Cigar Chew Cigarettes Pipe

Alcohol Use:
 No
 Yes _____ Times per week
Type (Circle One): Beer Wine Liquor

Recreational Drug Use:
 No
 Yes

Socioeconomics

Occupation - _____ Employer - _____

Family - Marital Status _____
 Spouse's Name _____
 Number of Children _____

Education – Number of years _____