CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

PATIENT HISTORY

Name: _____ Age: _____ Ht: _____ Wt: _____

Primary Care Physician: _____

Drug Allergies: _____ Smokeless Tobacco: ☐ Yes ☐ No

Use of Recreational Drugs: ☐ Yes ☐ No Smoker: ☐ Yes ☐ No

Alcohol: ☐ Socially ☐ One Per Day ☐ 2 or More Per Day ☐ None

Cardiac problems or questions to be addressed:

1._____

2._____

3._____

CURRENT MEDICATION

MEDICATION	DOSAGE	FREQUENCY

PAST HOSPITALIZATION AND/OR SURGERIES

PROCEDURE	DATE

Have you experienced any of the following (Check if YES):

☐ High Blood Pressure
☐ Diabetes
☐ Elevated Cholesterol
☐ Palpitations
☐ Syncope (loss of consciousness)
☐ Chest Pain
☐ Shortness of Breath
☐ Increased Fatigability
☐ Dizziness

PERTINENT PAST CARDIAC FAMILY HISTORY

Father: _____

Mother: _____

Brother/Sister: _____

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