207 Chartwell Court • Myrtle Beach, South Carolina 29588 • (843) 293-2700

NEW PATIENT INTAKE INFORMATION

PATIENT INFORMATION

Patient Name: ____ **Date:** ___________________

Date of Birth: ___________________

Do you have any of the following symptoms?

- ❑ Chest Pain / Tightness / Pressure
- ❑ Palpitations
- ❑ Irregular Heart Beat
- ❑ Poor Circulation (Claudication)
- ❑ Lack of Energy / Easy Fatigue
- ❑ Shortness of Breath
- ❑ Lightheadedness / Dizziness
- ❑ Substantial Weight Gain or Loss
- ❑ Fainting / Near Fainting
- ❑ Swelling of Feet and / or legs

Other Complaints:

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FOR OFFICE STAFF USE ONLY
Comments:
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ROS:
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HEART RELATED PROBLEMS

Have you had or been diagnosed with any of the following conditions?

- ❏ Heart Attack
- ❏ Angioplasty / Stent
- ❏ Bypass Surgery
- ❏ Congestive Heart Failure
- ❏ Syncope (fainting / loss of consciousness)
- ❏ Pacemaker
- ❏ Defibrillator
- ❏ Mitral Valve Prolapse
- ❏ Other Heart Valve Problems
- ❏ Heart Rhythm Problems
- ❏ Atrial Fibrillation
- ❏ Ventricular Fibrillation / Tachycardia

OTHER HEART PROBLEMS

Have you had or been diagnosed with any of the following other conditions?

- ❏ AIDS / HIV
- ❏ Anemia
- ❏ Arthritis
- ❏ Asthma
- ❏ Bleeding Disorders
- ❏ Cancer
- ❏ Cataracts
- ❏ Diabetes
  - ❏ Insulin Dependent
  - ❏ Non-insulin Dependent
- ❏ Emphysema / COPD
- ❏ Epilepsy / Seizures
- ❏ Glaucoma
- ❏ Hepatitis
- ❏ High Cholesterol
- ❏ High Blood Pressure
- ❏ Kidney Failure / Kidney Stones
- ❏ Liver Failure
- ❏ Migraine Headaches
- ❏ Multiple Sclerosis
- ❏ Pneumonia
- ❏ Prostate Problem
- ❏ Psychiatric Problem
- ❏ Depression
- ❏ Bipolar Disorder
- ❏ Schizophrenia
- ❏ Suicide Attempt
- ❏ Rheumatic Fever
- ❏ Sexually Transmitted Disease
- ❏ GERD
- ❏ Stroke / Mini-Stroke (TIA)
- ❏ Thyroid Problems
- ❏ Tuberculosis

Any other problems not mentioned above?

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PREVIOUS SURGERIES & DATES

Procedure:	Date:

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MEDICATIONS

Please list all medications:

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Any known allergies? If so, please describe:

____
____

SOCIAL HISTORY

Marital Status: ____________________________

Occupation: ____________________________

How many children: ____________________________

Tobacco use: ____________________________

Illicit drug use: ____________________________

Any other issues: ____
____
____

FAMILY HISTORY

Mother: ________________ **Father:** ________________ **Brother(s):** ________________

Sister(s): ________________ **Other:** ________________

First Degree Family Members: ____________________________

Family History of Sudden Cardiac Death: ____________________________

Family History of Congenital Heart Defects (Heart Defects at Birth): ____________________________

Family History of Premature Heart Attack: ____________________________

Other problems: ____________________________

Any other concerns or issues not mentioned above? Please describe: ____________________________
____
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