ADVANCED CARDIOLOGY ASSOCIATES
NEW PATIENT HISTORY & PHYSICAL

PATIENT NAME:_____ **DATE OF SERVICE:**_____
PATIENT ID#_____ **DATE OF BIRTH:**_____ **AGE:**_____ **SEX:**_____
WEIGHT:_____ **HEIGHT:**_____ **PULSE:**_____ **BLOOD PRESSURE:**_____

REASON FOR CONSULTATION:

	CHEST PAIN		DIZZINESS		PAROXYSMAL NOCTURNAL DYSPNEA		KNOWN HEART CONDITION
	SHORTNESS OF BREATH		SYNCOPE		SWELLING OF LEGS		OTHER:
	ORTHOPNEA		PALPITATIONS		INTERMITTENT CLAUDICATION		
	FATIGUE		SKIPPED HEART BEAT		HYPERTENSION		

PAST MEDICAL HISTORY:

	MYOCARDIAL INFARCTION		DIABETES		RESPIRATORY DISEASE		OTHER:
	HEART MURMUR		HIGH CHOLESTEROL		RHEUMATIC FEVER		
	HYPERTENSION		TRIGLYCERIDES		STROKE		

PAST SURGICAL HISTORY:_____

_____

FAMILY HISTORY:

FATHER:	**MOTHER:**

SOCIAL HISTORY:

MARITAL STATUS:	CHILDREN:	SMOKING:
OCCUPATION:	ALCOHOL:	COFFEE/CAFFEINE:

CURRENT MEDICATIONS:

ALLERGIES:
