MARYLAND CARDIAC CARE

NEW PATIENT MEDICAL HISTORY FORM

Patient Name:_____ **Age:**_____ **DOB:** _____

Date:_____ **Referring Doctor/Hospital:** _____

Other Doctors You See: _____

Reason for Visit: _____

_____

_____

Official Use Only

CC _____

HPI

Past Medical History
(*list surgeries/hospitalizations/major medical problems*)

1._____
2._____
3._____
4._____
5._____

Family History
(chronic illnesses, cause/age of death, etc.)

Mother: _____

_____

Father: _____

_____

Siblings: _____

_____

Social History

Occupation: _____

Marital Status (circle): Single Married Divorced Widowed

Alcohol Use: How many drinks consumed per day on average? _____

Smoking (circle): Yes No Quit on _____

How much:_____

Recreational Drug Use (circle): Yes No Quit on _____

How often: _____

What kind: _____

Do you exercise (circle): Yes No

How often/type: _____

Allergies to Medications

	Medication	Reaction
1.		
2.		
3.		
4.		

Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Review of Systems

Do you have any of the following? (circle)

Constitutional – fever, chills, unexplained weight change

Eyes – blurred or double vision, loss of vision, discharge

Ears – discharge, ringing, loss of hearing

Throat – hoarseness, trouble swallowing

Nose – bleeding, sinus problems

G.I. – vomiting, nausea, blood in stool, diarrhea, constipation

G.U. – blood in urine, painful urination, kidney stones

Neuro – unusual headaches, seizures, loss of consciousness, weakness of an extremity

Endo – excessive thirst, excessive urination, heat or cold intolerance

Skin – rash

Heme – easy bruising, anemia, swollen glandsAllergy/Immuno – seasonal allergies

Psych – anxiety, depression

Respiratory – cough, sputum production, blood in sputum, shortness of breath, asthma

Additional Past Medical History

Additional Family Medical History