NORTHERN
Cardiology
a department of Northern Regional Hospital

NEW PATIENT MEDICAL HISTORY

Name: _____ **Age:** _____ **Date of Birth:** _____ **Sex:** **M** **F**

Reason for Visit: _____

List Medications you are currently taking, including over-the-counter or non-prescription.

Medication Name	Strength	How often taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Allergies

☐ No known Drug Allergies ☐ No known other allergies

If you do have allergies:

☐ Drug Allergies: _____

☐ Food Allergies: _____

☐ Environmental (such as dust, tree pollen, etc.) _____

Past Medical History

Illnesses/conditions – please check the box next to any of the illnesses below that you have had or currently have.
Please check all that apply.

		Date/Details			Date/Details
Abnormal Pap/Periods	☐	Yes _____	Hernia	☐	Yes _____
Acid Reflux (chronic heartburn)	☐	Yes _____	High Blood Pressure	☐	Yes _____
Atrial Fibrillation	☐	Yes _____	High Cholesterol	☐	Yes _____
Allergies-Seasonal/Hay Fever	☐	Yes _____	Hyperthyroidism	☐	Yes _____
Anemia	☐	Yes _____	Hypothyroidism	☐	Yes _____
Asthma	☐	Yes _____	Irregular Heart Beat	☐	Yes _____
Arthritis	☐	Yes _____	Kidney Stones	☐	Yes _____
Back Pain	☐	Yes _____	Liver Disease	☐	Yes _____
Bleeding Ulcer	☐	Yes _____	Mental Disorder	☐	Yes _____
Blood Transfusions	☐	Yes _____	Nasal Polyp	☐	Yes _____
Breast Lump	☐	Yes _____	Osteoporosis	☐	Yes _____
Broken Bones	☐	Yes _____	Oxygen Use	☐	Yes _____
Bronchitis	☐	Yes _____	Peripheral Neuropathy	☐	Yes _____
Cancer (specify type)	☐	Yes _____	Pleurisy	☐	Yes _____
Cataract	☐	Yes _____	Pneumonia	☐	Yes _____
Chest Pain	☐	Yes _____	Prostate Disease	☐	Yes _____
Congestive Heart Failure COPD	☐	Yes _____	Rheumatic Fever	☐	Yes _____
Coronary Artery Disease	☐	Yes _____	Sinus Infection	☐	Yes _____
Diabetes (Type I or II)	☐	Yes _____	Skin Disease	☐	Yes _____
Emphysema	☐	Yes _____	Stroke	☐	Yes _____
Gall Bladder Disease	☐	Yes _____	Thrombophlebitis (blood clot)	☐	Yes _____
Gastric Ulcer	☐	Yes _____	Tonsillitis	☐	Yes _____
Gastric Bleeding	☐	Yes _____	Tuberculosis	☐	Yes _____
Heart Attack	☐	Yes _____	Ulcer	☐	Yes _____
Heart Disease	☐	Yes _____	Urinary Infection	☐	Yes _____
Heart Murmur	☐	Yes _____	Venereal Disease	☐	Yes _____
Hepatitis	☐	Yes _____			

Past Surgical History

		Date/Details			Date/Details
Abdominal Aneurysm Repair	☐	Yes _____	Gallbladder Surgery	☐	Yes _____
Adenoidectomy	☐	Yes _____	Heart Surgery	☐	Yes _____
Appendectomy	☐	Yes _____	Hernia Repair	☐	Yes _____
Angioplasty	☐	Yes _____	Hysterectomy	☐	Yes _____
Back Surgery	☐	Yes _____	Kidney Surgery	☐	Yes _____
Breast Surgery	☐	Yes _____	Lung Surgery	☐	Yes _____
Cardiac Ablation	☐	Yes _____	Open Heart Surgery	☐	Yes _____
Cardiac Stent Insertion	☐	Yes _____	Orthopedic/Bone Surgery	☐	Yes _____
Carotid Endarterectomy	☐	Yes _____	Pacemaker Implantation	☐	Yes _____
Cataract Removal	☐	Yes _____	Sinus Surgery	☐	Yes _____
Colon Surgery	☐	Yes _____	Thyroid Operation	☐	Yes _____
Defibrillator Placement	☐	Yes _____	Tonsillectomy	☐	Yes _____

Family Medical History

Has anyone in your **IMMEDIATE** family (father, mother, sibling, grandparent, children) been diagnosed with any of the following conditions?

		Relationship			Relationship
Asthma	☐	Yes _____	Heart Disease	☐	Yes _____
Cancer-type?	☐	Yes _____	High Blood Pressure	☐	Yes _____
Bleeding Disorder	☐	Yes _____	Stroke	☐	Yes _____
COPD/Chronic Lung Disease	☐	Yes _____	Thyroid Disease	☐	Yes _____
Diabetes	☐	Yes _____	Tuberculosis	☐	Yes _____

Other not listed:

_____

_____

Social History

Your Personal Habits: Do you…

Regularly exercise (3-4 times weekly)	☐ Yes	☐ No	(If yes, type and frequency: _____)
Use illegal drugs	☐ Yes	☐ No	(If yes, type and frequency: _____)
Use alcohol	☐ Yes	☐ No	(If yes, type and frequency: _____)
Smoke	☐ Yes	☐ No	(If yes, type and frequency: _____)
Smokeless tobacco	☐ Yes	☐ No	(If yes, type and frequency: _____)
Previous Smoker	☐ Yes	☐ No	(If yes, quit date: _____)

Do you have any advanced directives? (Living Will, Health Care Power of Attorney, Do Not Resuscitate)
If yes, please specify: _____

Are you an organ donor?_____

Do you have any cultural, religious or personal beliefs we should be aware of?
If yes, please specify: _____

Preferred Language for discussing your health care:_____