CENTRAL CONNECTICUT CARDIOLOGISTS, LLC

Patient History

Name:	Date:	
Referring M.D.:	DOB:	Sex:
Chief Complaint:		

1. Please circle if you have or ever had any of the following:

Shortness of breath	Change in bowel habits	Congestion	Anxiety/panic
Asthma	Peptic ulcer	Nosebleeds	Depression
Fluid in lungs	Constipation	Excessive thirst	Allergies
Wheezing	Liver disease	Diabetes	Drug allergies
Emphysema	Black stools	Thyroid	Adverse drug reaction
Bronchitis	Blood in stools	Unusual fatigue	
Difficulty breathing	Frequent bowel movements		
Chronic cough	Abdominal pain	Easy bruising	Menstrual irregularities
Cough up blood	Stroke	Unexplained weight loss	Menopause date
High blood pressure	Fainting spells	Unexplained weight gain	
Irregular heart rate	Lightheadedness	Burning on urination	
Heart murmur	Slurred speech	Frequent urination	
Enlarged heart	Weakness	Kidney problems	
Heart attack	Shaking	Blood in urine	
Palpitations	Visual disturbance	Arthritis	
Fluttering of the heart	Loss of vision	Pain in legs while walking	
Chest pain	Blurred vision	Swelling of the ankles	
Chest discomfort	Double vision	Swelling of the legs	
Cholesterol or lipid disorder		Varicose veins	
Awakened at night by shortness of breath		Muscle pain/tenderness	

2. Social History: Do you have any of the following risk factors for heart disease:

Heart disease in family	Obesity	Sedentary life style
Stressful lifestyle	Drink alcohol Quantity	
Smoke cigarettes Packs per day	How long	Use of unlawful drugs

3. Past History: Have you ever had:

Test	Date	Location
Electrocardiogram (EKG)		
Chest X-ray		
Exercise Test		
Exercise Test with Isotope		
Echocardiogram		
Angioplasty/Stent		
Cardiac Catheterization		
Cholesterol Test		
Cardiac Surgery		
Pacemaker Implant		
Defibrillator		

Please turn over

Patient Name _____ Date of Birth _____

4. Past Hospitalization (list with dates and problems):

Hospital	Date	Problem

5. Family History:

	Age	Living	Deceased	Cause or disease
Mother				
Father				
Brother(s)				
Sisters(s)				

Has anyone in your family ever had:

High blood pressure Diabetes

Stroke Heart disease

6. Allergies:

Substance	Reaction

7. Medications:

Name	Dosage	Times Per Day

Physician Signature _____