



One Webster Avenue, Suite 307
 Poughkeepsie, NY 12601
 845-483-5352 Fax 845-485-3804

PATIENT HISTORY FORM

Name: _____ Birth Date: _____ Age: _____ Date: _____

Referring MD: _____ Primary MD: _____

Height _____ Weight _____ Gender _____ Marital Status S ___ M ___ W ___ D ___ Number of Children _____

Chief Complaint: _____

Illness: _____

Prior Surgeries/Year: _____

List Present Medications (or attach list): _____

List any over the counter drugs (or attach list): _____

List any herbal medicine or vitamins: _____

List all medication ALLERGIES: _____

	NO	YES	How long/much
Do you drink alcoholic beverages?	_____	_____	_____
Do you currently smoke?	_____	_____	_____
Have you ever smoked?	_____	_____	_____
Do you have elevated cholesterol?	_____	_____	_____
Are you generally stressed?	_____	_____	_____
Do you drink beverages containing caffeine?	_____	_____	_____
Do you exercise?	_____	_____	

If yes what is your routine: _____

Are you following a special diet? _____

If yes describe: _____

Occupation: _____

Describe your job tasks: _____

Are you retired?	NO	YES
	_____	_____
Are you disabled?	_____	_____

If yes describe your disability: _____

FAMILY HISTORY:

Family Member(s)	Alive	Deceased	Current Age or Age at Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Do you have FAMILY history of:

	NO	YES	WHO
1. Heart Disease	_____	_____	_____
2. High Blood Pressure	_____	_____	_____
3. Diabetes	_____	_____	_____
4. Stroke	_____	_____	_____
5. Cancer (location)	_____	_____	_____
6. Thyroid Disease	_____	_____	_____
7. Abdominal Aortic Aneurysm	_____	_____	_____
8. Peripheral Vascular Disease	_____	_____	_____
9. Other Disease	_____	_____	_____

Do you have now or have you recently had any of the following:

	NO	YES	Please Explain
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Chest Pain/Pressure	_____	_____	_____
Heart Failure	_____	_____	_____
Rapid Heart Beat or Irregular Pulse	_____	_____	_____

	NO	YES	Please Explain
Swollen Ankles	_____	_____	_____
Pain in calf muscles when walking	_____	_____	_____
Aneurysm	_____	_____	_____
Varicose Veins	_____	_____	_____
Spider Veins	_____	_____	_____
Light Headedness	_____	_____	_____
Dizziness	_____	_____	_____
Migraine headaches	_____	_____	_____
Fatigue	_____	_____	_____
Seizure	_____	_____	_____
Depression	_____	_____	_____
Menstrual dysfunction	_____	_____	_____
Venereal Disease	_____	_____	_____
Anxiety	_____	_____	_____
Arthritis	_____	_____	_____
Back Pain	_____	_____	_____
Blood Disease or Anemia	_____	_____	_____
Autoimmune Disease	_____	_____	_____
Allergies/Hay fever	_____	_____	_____
Cough	_____	_____	_____
Shortness of Breath	_____	_____	_____
Asthma or Emphysema	_____	_____	_____
Lung Cancer	_____	_____	_____
Cancer (location)	_____	_____	_____
Scarlet Fever	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Thyroid Disease	_____	_____	_____

	NO	YES	Please Explain
Hepatitis (Jaundice or Liver Disease)	_____	_____	_____
Kidney Stone(s)	_____	_____	_____
Blood in Urine	_____	_____	_____
Urinary Problem	_____	_____	_____
Ulcer	_____	_____	_____
Colitis	_____	_____	_____
Rectal Bleeding	_____	_____	_____
Stomach or bowel disorder	_____	_____	_____
Change in Bowel Habits	_____	_____	_____
Black Tarry Stool	_____	_____	_____
Constipation	_____	_____	_____
Gout	_____	_____	_____
Nervous Disorder	_____	_____	_____
Other _____			

Have you ever had any of the following heart studies?

EKG
 Echocardiogram
 24 Hour monitor
 Cardiac Nuclear Stress Test
 Cardiac Catherization
 Treadmill (stress test)
 Chest x-ray

Other _____

Have you ever had a reaction to the dye used in certain Radiologic & cardiac x-rays? (i.e. CT Scan dye)

YES
 NO
 I have never had this type of x-ray

_____ **M.D.**