

SOUTH ORANGE COUNTY CARDIOLOGY GROUP

Jeffrey F. Feiner, M.D., F.A.C.C.
Robert K. Masters, M.D., F.A.C.C.
Douglas P. Lyle, M.D., F.A.C.C.
Michael J. Gault, M.D., F.A.C.C.
Daniel H. LaMont, M.D., F.A.C.C.
Howard I. Frumin, M.D., F.A.C.C.
Ronald D. Gim, M.D., F.A.C.C.

PATIENT NAME (PLEASE PRINT)

DO YOU NOW OR HAVE YOU EVER HAD (PLEASE CHECK ALL THAT APPLY):

- | | | |
|--|--|---|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> IRREGULAR HEART BEAT | <input type="checkbox"/> HEART MURMUR |
| <input type="checkbox"/> HEART FAILURE | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ANGINA | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> GOUT | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> ENLARGED HEART | <input type="checkbox"/> TROUBLE WITH CHILDBIRTH | <input type="checkbox"/> SEVERE INJURY |
| <input type="checkbox"/> ULCER DISEASE | <input type="checkbox"/> TUMORS | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> STROKE (CVA) |
| <input type="checkbox"/> HARDENING OF ARTERIES | <input type="checkbox"/> ELEVATED CHOLESTEROL | |

SURGERIES:

1. _____
2. _____
3. _____
4. APPENDECTOMY YES NO IF YES, WHEN?
5. TONSILLECTOMY YES NO IF YES, WHEN?

DATE OR AGE:

FAMILY HISTORY:

PRESENT AGE OR AGE AT DEATH

MEDICAL PROBLEMS OR CAUSE OF DEATH
(ESPECIALLY IF HEART DISEASE)

- | | | | |
|-----------|-------|-------|-------|
| 1. MOTHER | _____ | _____ | _____ |
| 2. FATHER | _____ | _____ | _____ |

ANY OTHER BLOOD RELATIVES WITH DIABETES, HIGH BLOOD PRESSURE OR HEART DISEASE? _____

ALLERGIES TO MEDICATIONS:

1. _____ 2. _____ 3. _____

CURRENT MEDICATIONS AND DOSE:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

DO YOU OR DID YOU SMOKE? YES NO PACKS PER DAY _____ HOW MANY YEARS? _____
WHEN DID YOU QUIT? _____

ALCOHOL CONSUMPTION PER DAY: _____

CAFFEINE CONSUMPTION PER DAY: _____

OCCUPATION (OR RETIRED): _____

LEVEL OF STRESS: VERY HIGH HIGH MEDIUM LOW

SEXUAL ACTIVITY: SATISFACTORY UNSATISFACTORY