Ocean Heart Group Medical History

Basic patient details

First name	Initials	Second name

Age

Height

Weight

What is the problem you have been having?

Allergies

Recent testing done?

Have You ever had a heart catheterization?

Angioplasty?

Bypass surgery?

Previous echocardiogram?

Previous carotid ultrasound?

Previous stress test?

Medications

Please list ALL medications, prescription or non-prescription, which You are CURRENTLY taking and include how many time per day You are taking them and the strength:

1

2

3

4

5

6

7

8

9

10

Do You take Aspirin or other Blood thinners?

Herbal medications?

Vitamins?

Basic patient details

Hospitalizations or Operations?

Year	Reason for Hospitalization	Diagnosis

Heart Problems
○ Yes ○ No

Astma
○ Yes ○ No

Murmur / Valve Problems
○ Yes ○ No

COPD
○ Yes ○ No

Bladder Problems
○ Yes ○ No

High Blood Pressure
○ Yes ○ No

Emphysema
○ Yes ○ No

Prostate Problems
○ Yes ○ No

Irregular Heart Beat
○ Yes ○ No

Breathing Problems
○ Yes ○ No

Peripheral Vascular Problems
○ Yes ○ No

Seizure Disorders
○ Yes ○ No

Chest Pain
○ Yes ○ No

Anemia
○ Yes ○ No

Arthritis
○ Yes ○ No

CVA, TIA (Stroke)
○ Yes ○ No

Thyroid Problems

Stomach Problems

○ Yes ○ No ○ Yes ○ No

Please list any other Medical Conditions

Family History

Any immediate family members have a history of the following?

Diabetes
○ Yes ○ No

High Blood Pressure
○ Yes ○ No

Cancer
○ Yes ○ No

Anemia
○ Yes ○ No

Asthma
○ Yes ○ No

High Cholesterol
○ Yes ○ No

Arthritis
○ Yes ○ No

Thyroid Problems
○ Yes ○ No

Heart Disease
○ Yes ○ No

Stroke
○ Yes ○ No

Kidney Problems
○ Yes ○ No

Pancreatic Problems
○ Yes ○ No

Social History

Occupation

Martial Status

Children (ages)

Do You smoke?

If Yes, how much?

Do You drink co�ee, tea?

Cups per day?

Do You drink alcohol?

If Yes, how much?

Do You experience high anxiety?

Do You follow a special diet?

For Sta� Use

Recent Testing Results Received

Medical Records Release Received

Hospitalization Records Received

Assignment of Insuracne Benefits: I reqest that payment of authorized benefits by made on my behalf by any Insurance Company involved in my benefits, Medicare or Medicaid to Ocean Heart Group authorize release of medical information to Medicare (HCFA), Medicaid, or any insurance involved in my benefits.

Patient signature

Date

☐ I agree with the above conditions