Cardio Terra, Ltd
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CARDIO TERRA, LTD
JERRY J. BOLEY, MD, FACC

OFFICE USE ONLY

PS Acct#_____

ADULT PATIENT HISTORY FORM

NAME:_____**DOB:**_____**DATE:**_____

Marital Status: M/S/W/D **Occupation:**_____**Employer:**_____

Do you or have you ever smoked? Y/N **If yes, how much?**_____**how long?**_____

Do you drink alcoholic beverages? Y/N **If yes, how much?**_____**per day?**_____**week?**_____

Do you consume caffeine? Y/N **If yes, how much?**_____**per day?**_____**week?**_____

Do you exercise regularly? Y/N If yes, what type of exercise?_____**how often?**_____

PAST MEDICAL HISTORY: Please list any medical conditions for which you have been treated in the past.

Medical Condition	Date of Onset	Medical Condition	Date of Onset
1		2	
3		4	
5		6	
7		8	
9		10	

PAST SURGICAL HISTORY: Please list any surgeries that you have had along with the date of the surgery.

Surgery/Procedure	Date	Surgery/Procedure	Date
1		2	
3		4	
5		6	

MEDICATIONS: Please list all medications you are taking, including over-the-counter medications and herbal supplements. Please include dose and frequency.

Medication	Dose	Freq.	Medication	Dose	Freq.
1			**2**		
3			**4**		
5			**6**		
7			**8**		
9			**10**		
11			**12**		
13			**14**		

NAME:_____**DOB:**_____**DATE:**_____

ALLERGIES: If you have no known drug allergies, please check this box ☐

Please list all medications you are allergic to and what occurs/has occurred when you take that medication.

Allergic Medication	Reaction	Allergic Medication	Reaction
1		2	
3		4	
5		6	

FAMILY HISTORY: For each of the following family members, please list their age (or age at death), if known and any illnesses including: diabetes, high blood pressure, heart disease, cancer, kidney problems, liver problems, lung problems, depression, allergies or arthritis.

MOTHER	**FATHER**
SIBLINGS	**CHILDREN**

IF YOU HAVE A CARDIAC DEVICE, PLEASE COMPLETE THE FOLLOWING:

Implanted Cardiac Device: Pacemaker____ ICD (Implantable Cardioverter Defibrillator___ Other_____

Company of implanted device: Boston Scientific (Guidant)___ Medtronic___ St. Jude Medical___ Other___

Implanting physician_____ Following physician_____

Date of last device follow up appointment performed in the office_____ remotely_____

Would you like to transfer device follow up care to Cardio Terra, Ltd? _____YES _____NO

PLEASE BRING YOUR DEVICE ID CARD WITH YOU TO YOUR APPOINTMENT SO THAT WE CAN MAKE A COPY FOR OUR RECORDS. Thank you.

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NAME:_____**DOB:**_____**DATE:**_____

REVIEW OF SYSTEMS: Please check if you have been experiencing any of the symptoms below within the last 6 months:

GENERAL: fever____ chills____ headaches____ night sweats____unexplained weight loss/gain____ fatigue____ appetite changes____

EYES: eye pain with sunlight____ vision changes____ redness____ discharge____ pain____ itching____ glasses____ glaucoma____ cataracts____

EARS/NOSE/THROAT: hearing loss____ ringing in ears____ nosebleeds____ runny nose____ nasal congestion____ earache____ post nasal drip____ sore throat____ mouth sores____ dentures____

HEART: palpitations____ leg swelling____ passing out____ leg pain while walking____ chest pain____ difficulty breathing at night____

LUNGS: cough____ coughing up blood____ shortness of breath____ wheezing____ coughing up phlegm____

GI: belly pain____ nausea____ vomiting____ diarrhea____ constipation____ bloody stools____ dark stools____ heartburn____ trouble swallowing____

URINARY TRACT: pain with urination____ blood in urine____ sudden urge to urinate____ decreased stream____ urinating more frequently____ incontinence____

MUSCULOSKELETAL: joint pain____ stiffness____ weakness____ joint swelling____ back pain____ muscle pain____ muscle cramps____

SKIN: itching____ redness____ hair loss____ nail change____ rash____ moles____ dry skin____

NEUROLOGIC: memory loss____ numbness____ difficulty walking____ difficulty speaking____ dizziness____ tremor____

PSYCHIATRIC: depression____ suicidal thoughts____ homicidal thoughts____ hallucinations____ mood changes____ anxiety____ sleep disturbance____

ENDOCRINE: hot/cold intolerance____ hair changes____ increased urination____ increased thirst____

HEMATOLOGY: anemia____ easy bruising____ bleeding of skin/gums____ swollen glands____

ALLERGY/IMMUNE SYSTEM: frequent infections____ breathing difficulties when exposed to allergens____ environmental allergies____

PLEASE SIGN AND DATE BELOW:

PATIENT SIGNATURE:_____**DATE:**_____

PHYSICIAN SIGNATURE:_____**DATE:**_____

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