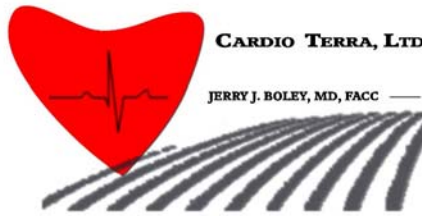


Cardio Terra, Ltd
 4112 Monroe Road
 Celina, OH 45822-9250
 567-890-9000 Phone
 567-890-9009 Fax



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.

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: _____