CARDIOLOGY CONSULTANTS OF ATLANTA, P.C.
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Board Certified in Cardiology

New Patient Health Questionnaire
(May use back if necessary)

Patient Name: _____

Reason for Today's Visit: _____

Past Medical History: (list all medical conditions that you have been diagnosed with by a physician (note: may place more than one diagnosis per line))

Medical Condition	**Year Diagnosed**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History (list all surgeries performed)

Surgery	**Year Diagnosed**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications

Medication Name	Dosage/Strength (mg., mcg)	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: (Name, Address, Phone Number) _____

Marital Status: ___Single ___Married ___Divorced/Separated ___Widow
Children: ___Yes ___No If Yes, Ages: _____
Occupation: _____

Personal Habits

Do you smoke or chew tobacco? ___Yes ___No **Packs per day?** _____
Have you smoked in the past? ___Yes ___No **Yr Started** ___ **Stopped** ___
Do you exercise regularly? ___Yes ___No **how often?** _____
ETOH (alcohol), and/or Recreational Drugs:
_____

Family History (Please circle if you or immediate family (brothers, sisters, mother, father) have had any of the following:

Premature (Early) Heart Attack	**Yes**	**No**	**Stroke**	**Yes**	**No**
Cardiomyopathy (Weak Heart)	**Yes**	**No**	**Diabetes**	**Yes**	**No**
Sudden Cardiac Death	**Yes**	**No**	**High Cholesterol**	**Yes**	**No**
Bleeding Problems	**Yes**	**No**	**Abnormal Heart Rate**	**Yes**	**No**

Current Physicians

Primary Care/Family Physician: _____

Referring Physician: _____

Specialty Physicians: _____
