Cardiology Associates of Ocean County, P.A.
Medical History Form

Name: ______________________________ Date: ______________

Age: ________ D.O.B.: ______________________ Marital Status: S M W

Allergies: (Medication) ______________________ Allergy: Shellfish/Iodine yes no

Current Symptoms: ______________________________

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Chest discomfort with exercise	yes	no	Palpitations or heart fluttering	yes	no
Chest discomfort at rest	yes	no	Ankle or leg swelling	yes	no
Night sweats	yes	no	Unusual fatigue	yes	no
Shortness of breath	yes	no	Nausea	yes	no

PERSONAL HISTORY:

Heart Disease	yes	no	Thyroid Disorder	yes	no
Heart Attack	yes	no	Lung Disease	yes	no
High Blood Pressure	yes	no	Diabetes	yes	no
High Cholesterol	yes	no	Seizures	yes	no
Heart Valve Disease	yes	no	Liver Disorders	yes	no
Stroke	yes	no	Kidney Disease	yes	no
Other: ______________			Other: ______________		

FAMILY HISTORY: (check off if any members listed below had the following diagnoses)

	MOTHER	FATHER	SIBLINGS	GRANDPARENTS Maternal	GRANDPARENTS Paternal
Heart Attack					
Rheumatic Heart Disease					
Heart Disease Other (specify)					
High Blood Pressure					
Stroke					
High Cholesterol					
Lung Disease (specify)					
Diabetes					
Cancer (specify)					
Kidney Disease					
Other (specify)					

Age: Mother ____ Father ____ Grandmother ____ Grandfather ____

SURGERIES AND OR HOSPITALIZATIONS:

DATE	REASON	NAME OF HOSPITAL

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSTIC TESTS:

	DATE	PLACE OF SERVICE
Regular Exercise Stress Test		
Nuclear Stress Test		
Echo Cardiogram		
Cardiac Catheterization		
Stents/Angioplasty		
Vascular Tests		
Vascular Stent/Angioplasty (LEGS)		
Pacemaker Implant		
Defibrillation Implant		

OFFICE USE ONLY: Dr. ______________ Date ____________