Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY
CLINICAL CARDIAC ELECTROPHYSIOLOGY

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ (☐ Home ☐ Cell ☐ Work) E-Mail: _____

Primary Insurance Company: _____ Policy #:_____

Primary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Secondary Insurance Company: _____ Policy #:_____

Secondary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ Aspirin		☐ Latex	
☐ Doxycycline		☐ Other:	
☐ Flomax		☐ Other:	
☐ Macrobid		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Sulfa		☐ Other:	

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking)

Name of Medication/Herb/Vitamin	**Dosage** (mg/ml)	**Frequency**

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY PC

Patient Name: _____ Date of Birth: _____

CHIEF COMPLAINT TODAY (Please check the reason for your visit today)

☐ Abnormal EKG	☐ Coronary Artery Disease	☐ Pacemaker Check/Programming
☐ Abnormal Stress Test	☐ Diabetes	☐ Palpitations
☐ Arm Pain	☐ Dizziness	☐ Peripheral Vascular Disease
☐ Arrhythmia	☐ Dyslipidemia	☐ Shortness of Breath
☐ Atrial Fibrillation	☐ Fatigue	☐ Syncope
☐ Cardiomyopathy	☐ Fever	☐ Valvular Heart Disease
☐ Chest Pain	☐ Hospital Follow-up	☐ Ventricular Tachycardia
☐ Congestive Heart Failure	☐ Murmur	☐ Other:
		☐ Other:

PAST MEDICAL HISTORY (Please check those items that apply)

☐ Anesthesia Problems	☐ COPD	☐ Mitral Valve Disease
☐ Aortic Valve Disease	☐ Coronary Artery Disease	☐ Peripheral Vascular Disease
☐ Asthma	☐ Deep Vein Thrombosis	☐ Prior Heart Attack
☐ Atrial Fibrillation	☐ Diabetes	☐ Stroke/TIA
☐ Bleeding Problems	☐ GERD/Reflux	☐ Other
☐ Congenital Heart Disease	☐ Hypertension	☐ Other
☐ Congestive Heart Disease	☐ Kidney Disease	☐ Other

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	Date of Surgery	Procedure	Date of Surgery
☐ Abdominal Surgery		☐ HEENT Surgery	
☐ AICD		☐ Orthopedic Surgery	
☐ Cardiac Catheterization		☐ Pacemaker	
☐ Cardiac Surgery		☐ Tonsillectomy/Adenoidectomy	
☐ Cardioversion		☐ Vascular Surgery	
☐ Coronary Artery Stent		☐ Other	
☐ Gastrointestinal Surgery		☐ Other	
☐ Genitourinary Surgery		☐ Other	

FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Arrhythmia			
☐ Arthritis			
☐ Coronary Arteriosclerosis			
☐ Disorder of Lung			
☐ Heart Disease			
☐ Myocardial Infarction			
☐ Sudden Cardiac Death			
☐ Other:			

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☐ Other:			

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Specific ☐ Carbohydrate ☐ Cardiac ☐ Diabetic

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day ☐ Current Status Unknown

Smoking – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week Has smoked since age _____

Chewing Tobacco - How much? ☐ None _____Per Day

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Alcohol – Years of Use: _____

Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit Drugs: _____

Advance Directive: ☐ Yes ☐ No