Emilio Del Priore, M.D.
Cardiovascular Specialist
230 Hilton Avenue Suite 110
Hempstead, NY 11550
Phone: (516) 565-5500 Fax: (516) 565-5502

PATIENT HISTORY FORM

Name	
Date of Birth	
Social Security Number	
Referring Physician	
Reason for Visit	

CURRENT MEDICATION LIST

What is the name of the medication?	What is the dosage? (i.e. 5 mg)	How many tablets do you take at a time?	How many times a day do you take this medication?

Do you have any allergic reactions to medications? If yes, please describe the medication and the reaction.

_____
_____

Do you have any allergic reactions to IODINE, SEAFOOD or X-RAY CONTRAST DYE? If yes, please describe the reaction.

_____
_____

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CARDIAC RISK FACTORS

	No	Yes	Description
Have you ever used tobacco products?			
If yes, are you still using tobacco products? When did you first start?			
If you have quit using tobacco products, when did you quit?			
Describe your tobacco habit (# of packs/week)			

	No	Yes	Controlled w/diet or medication	Unsure
Do you have high cholesterol/hyperlipidemia?				
Do you have high blood pressure/hypertension?				
Do you have diabetes?				

PREVIOUS CARDIAC HISTORY

Have you ever had any of the following cardiac examinations?

	No	Yes	Date
Stress Test (EKG/Treadmill)			
Echocardiogram			
Holter Monitor			
Coronary CAT Scan			
Cardiac Catheterization (Angiogram)			
Electrophysiology Study (EP Study)			

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PREVIOUS CARDIAC HISTORY (CONT'D)

Have you ever had any of the following cardiac events occur?

	No	Yes	Date/Description
Heart Attack			
Angioplasty or Stenting in Heart			
Angioplasty or Stenting in Other Arteries			
Heart Bypass Surgery			
Surgery on Other Arteries			
Heart Valve or Other Heart Surgery			
Cardioversion			
Pacemaker			
Implanted Defibrillator			
Surgery on Varicose Veins			

PREVIOUS MEDICAL HISTORY

Have you ever had any of the following?

	No	Yes	Date/Description
Significant Infections or Childhood Illnesses			
Broken Bones or Severe Injuries			
Surgeries			
Any other Medical Problems or Previous Hospitalizations			

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SOCIAL HISTORY

	No	Yes	Description
Do you drink any alcohol? If yes, describe your consumption (#of drinks/week)			
Have you reduced or stopped drinking recently?			
Do you follow a special diet?			
Do you exercise regularly? If yes, describe your routine (# of days/week)			
Do you have a history of drug or alcohol abuse?			
Are you currently employed?			
What is your occupation?			
What is the highest level of education you have received?			
What is your marital status?			
Who do you live with?			

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FAMILY HISTORY

Has anyone in your immediate family (Parents/Siblings/Children) had any of the following?

	No	Yes	Description
Heart Attack			
Angioplasty			
Stenting of Arteries			
Bypass Surgery			
Blocked Arteries			
Sudden/Unexplained Death			
Unexplained Passing Out Spells			
Heart Rhythm Problems			
Heart Failure/Weakened Heart			
Aneurysm of the Brain			
Aneurysm of the Aorta			
Stroke			
Congenital Heart Disease (Birth Defect)			
Heart Surgery (Other than Bypass)			
High Cholesterol			
High Blood Pressure			
Diabetes			
Tuberculosis			
Bleeding Disorder			

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REVIEW OF SYSTEMS

Have you recently had any of the following?

GENERAL			
	No	Yes	Description
Weight Loss			
Weight Gain			
Increase/Decrease in Exercise Tolerance			
SKIN			
Change in Hair/Nails?			
Rashes or Sores?			
EYES			
Double Vision or Blurred Vision			
Diagnosis of Glaucoma			
Vision Loss			
EARS / NOSE / MOUTH / THROAT			
Partial/Complete Hearing Loss			
Frequent/Unusual Nose Bleeds			
Hoarseness			
Problems Swallowing Food/Getting Food Stuck in Throat			
Food/Liquid Frequently Going “Down the Wrong Pipe”			
RESPIRATORY			
Shortness of Breath			
Short of Breath While Lying Down/Waking up Short of Breath			

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REVIEW OF SYSTEMS (CONT'D)

RESPERATORY (CONT'D)			
	No	Yes	Description
Chronic Cough or Wheeze			
Coughing up Blood			
Heavy Snoring/Falling Asleep Inappropriately?			
Been Told that You Stop Breathing While Sleeping?			
CARDIOVASCULAR			
Chest Pain/Tightness/Pressure			
Palpitations or Irregular Heart Beats			
Almost Lost or Lost Consciousness			
Pain/Cramps When Walking			
History of Blood Clots			
Swelling in Legs			
Any Other Cardiovascular Problem			
GASTROINTESTINAL			
History of Ulcers/Intestinal Blood Loss			
Recent Blood in Stool/Black Stools			
Frequent Indigestion/Acid Reflux			
Problems with Diarrhea/Constipation			
GENITOURINARY			
Trouble Urinating			
Blood in Urine			
History of Kidneys not Working Well			

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REVIEW OF SYSTEMS (CONT'D)

MUSCULOSKELETAL			
	No	Yes	Description
Unusual Muscle Pain or Tenderness			
History of Arthritis or Gout			
Joint or Back Pain			
NEUROLOGICAL			
Stroke or TIA			
Recent Loss of Strength or Sensation			
Loss of Ability to Talk			
Unusual Headaches			
Confusion			
Memory Loss			
PSYCHIATRIC			
Depression			
Stress			
Anxiety			
ENDOCRINE			
Cold Intolerance			
Heat Intolerance			
Being Very Thirsty			
Frequent Urination			
HEMATOLOGICAL			
History of Bleeding Disorder			
History of Anemia			
Bruising Easily			
HIV/AIDS Virus			

Thank you for taking the time to complete this Patient History Form. Please be sure to review your form, and make sure that each question was answered. The more we can understand about your personal medical history, the better we can serve you moving forward.