UNIVERSITY MEDICINE & CARDIOLOGY

Dr. Stamatis (Tom) Dimitropoulos
Board Certified Cardiology & Vein Diseases
Board Certified Interventional Cardiology

Medical History

Date: ____________________

WELCOME TO OUR OFFICE! Filling out this sheet provides us with information vital to your health and will aid us in accurately filing your insurance forms. Be assured that this information will remain strictly confidential. Please note this form is two-sided. We ask that you complete each section as fully as possible.

PATIENT INFORMATION

Patient's Full Name: ______________________ Date of Birth (DOB): ____________ Age: _____ Sex: M: _____ F: _____

Referred by: ☐ Dr. ______________________ ☐ Self or Friend: ______________________

MEDICATIONS

Please list all medications you are currently taking including dietary supplements: ______________________

____

____

ALLERGIES

Please list all allergies: ______________________

____

____

SYSTEM REVIEW: Please check all that apply and add any other important problems

PERSONAL HISTORY OF FAINTING: ☐ NO ☐ YES: (explain): ______________________

Skin
- ☐ Normal
- ☐ Abnormal Healing
- ☐ Other Skin Disorders: ______________________

Infections
- ☐ None
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tuberculosis

Constitutional
- ☐ None
- ☐ Weight Loss
- ☐ Fever
- ☐ Other: ______________

Ears/Eyes/Nose/Throat
- ☐ Normal
- ☐ Glaucoma
- ☐ Hearing Aid
- ☐ Plastic Surgery

Cardiovascular
- ☐ Normal
- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Hypertension
- ☐ Heart Attack - Date:

Respiritory
- ☐ Normal
- ☐ Asthma
- ☐ Emphysema
- ☐ Other: ______________________

Gastrointestinal
- ☐ Normal
- ☐ Stomach Ulcer
- ☐ Colitis
- ☐ Liver Damage
- ☐ Other: ______________

Musculoskeletal
- ☐ Normal
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Other: ______________________

Neurological
- ☐ Normal
- ☐ Stroke
- ☐ Seizure
- ☐ Other: ______________

Psychiatric
- ☐ Normal
- ☐ Depression
- ☐ Anxiety Attacks
- ☐ Other: ______________

Endocrine
- ☐ Normal
- ☐ Diabetes
- ☐ Thyroid
- ☐ Kidney Disease

Hemotologic/Lymphatic
- ☐ Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Enlarged Lymphnodes

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Medical History

PAST HISTORY

Medical History: (list any other medical problems) ______________________________

____

____

Major Hospitalizations: (list any other medical problems) ______________________________

____

____

Family History: Mom: Dad: Brother: Sister:

Social History: Occupation: ____________________ Marital Status: S: _____ M: _____ W: _____ D: _____

Smoking: ☐ NO ☐ Former ☐ YES, packs per day: ________ **Alcohol:** ☐ NO ☐ Social/Occasional only

Do you wear: ☐ Dentures ☐ Glasses ☐ Contact Lenses ☐ Hearing Aid ☐ Artificial Limb/Joint

Alcohol or Drug problems/addictions: ☐ NO ☐ YES, describe: ______________________________