

## DEMOGRAPHICS

Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First M/I

Responsible Party if Minor: \_\_\_\_\_ Sex: ☐ Male ☐ Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Group Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

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## PAST MEDICAL HISTORY / SOCIAL HISTORY (Check All That Apply)

☐ Hypertension (High Blood Pressure)

☐ Diabetes

☐ High Cholesterol

☐ Coronary Artery Disease

☐ Heart Attack

☐ Stroke

☐ Heart Failure

☐ Heart Murmur

☐ Family History of Heart Disease

☐ Leg Claudication

☐ Arrhythmias

☐ Smoking / Tobacco Use

Packs / Day: \_\_\_\_\_

How Long? \_\_\_\_\_

☐ Alcohol

☐ Drugs

☐ Rheumatic Fever

☐ Shortness of Breath

☐ Angioplasty / Stent

☐ Catheterization

☐ Bypass Surgery

☐ Other Surgery: \_\_\_\_\_

☐ Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☐ Any other conditions of  
concerns that we should be  
aware of: \_\_\_\_\_

\_\_\_\_\_

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