COOPER CONCIERGE
CARDIOLOGY & INTERNAL MEDICINE

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PATIENT INFORMATION:

Name: ____ Date of Birth: _______________________

Referred by: ____

Reason for visit: ____
How long have you had these symptoms? ____________________

PAST MEDICAL HISTORY:

	Yes	No	How Long?
High blood Pressure:	_____.	____.	_________________.
Diabetes	_____	___	_________________
Chest Pain	___	___	________. _________
Heart Attack	___	___	________________
Breathing Problems	_______	_____	_________________
Stroke	———	______	________________
High Cholesterol	_____	_____	_________________
Cancer	______	______	__________________
Other	______	_______	__________________

PAST SURGICAL HISTORY: ____.

Have you been hospitalized in the past 5 years? Why? _______________________________

FAMILY HISTORY: Father: _________________ Mother: ____________________________

CURRENT MEDICATIONS (list all prescription, non-prescription, and vitamins):

Allergy to any medication:____
Do you smoke? _________ How Much? ___________ How Long? ______ Quit when?___________
Do you drink caffeine (including coffee, soda etc?________________How much?______
Do you drink alcohol?_________How Much? __________________________________

Have you had any of the following symptoms? (Circle)
Weight loss/ gain Heart racing/palpitations Feeling faint Use walker or wheelchair