First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Med. Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*SOCIAL SECURITY # ( FOR BILLING PURPOSES ONLY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Do you have any Allergies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any of the following medications:

Aspirin 81 mg Aspirin 325 mg  Plavix (Clopidogrel) Brilinta Effient

Statin/cholesterol medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood thinner: Eliquis/ Xarelto/ Pradaxa/ Coumadin/ Warfarin

SOCIAL HISTORY: (Check all that Apply)

1. Do you currently smoke?  Yes/ No

If Yes, How many years have you smoked for? \_\_\_\_\_\_\_\_\_

If Yes, At what age did you start smoking? \_\_\_\_\_\_\_\_\_

If Yes, How many packs per day do you smoke? ½ pack 1 pack

1. Are you a Former smoker?  Yes/  No

If Yes, How many years did you smoked for? \_\_\_\_\_\_\_\_\_

If Yes, At what age did you start smoking? \_\_\_\_\_\_\_\_\_

1. Do you use any other forms of tobacco or nicotine?  Yes/ No
2. What is your level of alcohol consumption? None/ Occasional/ Moderate/ Heavy
3. Do you use any illicit or recreational drugs? Yes/ No
4. What is your level of caffeine consumption? None/ Occasional/ Moderate/ Heavy

Family History: Do any family members have any of the following conditions:

Father  Aortic Aneurysm  Bleeding Disorder  DVT  Heart Disease

Mother  Aortic Aneurysm  Bleeding Disorder  DVT  Heart Disease

Siblings  Aortic Aneurysm  Bleeding Disorder  DVT  Heart Disease

List Previous Operations and Year

1. 4.

2. 5.

3. 6.

**TURN OVER**

Do you have any of the following:

 Anemia  Diabetes

 Anticoagulation therapy  Heart disease

 Arthritis  High cholesterol/hyperlipidemia

 Asthma  Hypertension/High Blood Pressure

 Atrial fibrillation  Kidney disease

 Bleeding disorder  Neurological disorder

 COPD/emphysema/asthma  Pacemaker

 Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pulmonary embolism

 Clotting disorder  Sleep disorder/Sleep Apnea

 Congestive heart failure  Stroke

 Coronary artery disease  Use oxygen at home

 Deep venous thrombosis  Varicose veins

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_**

Reason for Current Visit:

Describe the Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When /How/ Where it Started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequent are the symptoms/severity of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything make your symptoms better or worse? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_