1912 Alabama Hwy 157
Cullman, AL 35058
Phone (256) 737-2095
Fax (256) 737-2097
CullmanRegional.com

# NEW PATIENT HEALTH INFORMATION

**Patient Name**: ________________________________________ **Birth date**:____/____/____ **Date**:____/____/_____

**Referring Physician**:___________________________________ **Address:** ________________________________________

**Pharmacy Name:**__________________________________________________**Phone Number:** _______-_______-________

**Reason for today's visit**: ________________________________________________________________________________

**Please describe this problem**: ___________________________________________________________________________
____________________________________________________________________________________________________

| PRIOR SURGERIES | CURRENT/ PRIOR ILLNESSES/ INJURIES |
|---|---|
| | |
| | |
| | |
| | |
| | |

Please list ALL medications (prescription and non-prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

| MEDICATION | DOSAGE | MEDICATION | DOSAGE |
|---|---|---|---|
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CULLMAN REGIONAL
Cardiology Clinic

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Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin**? ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES**
(Please explain below)

| ALLERGY | TYPE | REACTION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below)

| **TYPE OF SMOKING** (cigarette, pipe marijuana, chew, etc.) | HOW MUCH | HOW LONG |
|---|---|---|
| | | |
| | | |

Do you drink alcohol? ☐ **NO** and never have ☐ **Socially Only** ☐ **Daily** Type: ☐ **Beer/ Wine** ☐ **Hard Liquor**

Occupation:_______________________________________ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Please describe any family health issue(s) below:

| FAMILY HISTORY | GOOD/ NONE | UNKNOWN | ILLNESSES/ REASON FOR DEATH |
|---|---|---|---|
| MOTHER | | | |
| FATHER | | | |
| SIBLING(S) | | | |
| OTHER HEREDITARY ILLNESS | | | |

Do you have a previous cardiologist? ☐ **NO** and never have ☐ **YES** (Please list below)

Cardiologist Name: ______________________________________________________________

Practice Name: ___________________________________________ Phone: ______________________________

Practice Address: ______________________________________________________________________________

**If you have listed a previous Cardiologist, please complete the Authorization for Use and Disclosure of Protected Health Information (PHI).**

**If you have completed the PHI form, please return this form to the office prior to your appointment so records can be obtained before scheduled appointment with our Cardiologist. If you have any questions please do not hesitate to call our office at (256) 737-2095.**

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**Do you have or have you ever had any of the following:**

| Symptoms/Illness | NO | Yes, please explain | Symptoms/Illness | NO | Yes, please explain |
|---|---|---|---|---|---|
| **CONSTITUTIONAL** | | | **SKIN** | | |
| Fever or chills | | | Psoriasis/Eczema, etc. | | |
| Weight Loss | | | Nipple Discharge | | |
| **HEMATOLOGIC** | | | Last Menstrual Cycle | | Date: |
| Bleeding Disorders | | | | | |
| HIV/Other Blood Diseases | | | | | |
| **ENDOCRINE** | | | **NEUROLOGICAL** | | |
| Diabetes | | | CVA | | |
| **MUSCULOSKELETAL** | | | Headaches | | |
| Autoimmune | | | TIA | | |
| Arthritis | | | **GENITOURINARY** | | |
| Mobility/Joint Problems | | | Blood in Urine | | |
| **GASTROINTESTINAL** | | | Problems Urinating | | |
| Bleeding ulcers | | | Prostate Problems | | |
| Diarrhea | | | Kidney Problems | | |
| Blood in Stool | | | **RESPIRATORY** | | |
| Polyps | | | Asthma | | |
| Liver Problems | | | COPD | | |
| **CARDIOVASCULAR** | | | Respiratory Failure | | |
| Heart Disease | | | Sleep Apnea | | |
| Deep Vein Thrombosis/DVT | | | **ENT** | | |
| Blood Clots in Lungs/Legs | | | Hearing Problems | | |
| High Blood Pressure | | | Sinus Problems | | |
| Heart Failure | | | **PSYCHIATRIC** | | |
| High Cholesterol | | | Mood Swings | | |
| Stents/Open Heart | | | Anxiety/Depression | | |
| Pacemaker | | | | | |
| Defibrillator | | | | | |

**Please list any other conditions/ illnesses not indicated above:** ____________________________________________

____________________________________________________________________________

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

**Patient Signature:**________________________________________________________**Date:**____/____/____