ALFIERI CARDIOLOGY
PREVENTION & INNOVATION

Patient Name: _____
DOB: ___/___/_____

Medications:
If you have a list, please provide it to the office staff upon arrival.

Pharmacy Name: _____ Phone Number: _____

MEDICATION NAME	MG	HOW OFTEN YOU TAKE IT

Medication Allergies:_____

Family History:

Mother:
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ Heart attacks
- ❑ Cardiomyopathy
- ❑ Atrial fibrillation
- ❑ Open Heart Surgery
- ❑ CHF (congestive heart failure)
- ❑ Cancer; What kind _____ _____
- ❑ Diabetes
- ❑ Stroke
- ❑ Other _____
- ❑ Heart Disease

Father:
- ❑ High Blood Pressure
- ❑ Heart attacks
- ❑ Cardiomyopathy
- ❑ Atrial fibrillation
- ❑ Open Heart Surgery
- ❑ CHF (congestive heart failure)
- ❑ Cancer; What kind _____ _____
- ❑ Diabetes
- ❑ Stroke
- ❑ Other _____

Medical History:

- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ Heart attacks; If so, where did you have it and about what year? _____
- ❑ Cardiac Cath
  - ❑ Stent Placement; If so, where did you have it and about what year?_____
- ❑ Open Heart Surgery
  - ❑ Bypass/ CABG
  - ❑ Valve replacement/Repair

  If so, where did you have it done and about what year?_____
- ❑ Cardioversion; If so, where did you have it and about what year? _____
- ❑ Cardiac Ablations; If so, where did you have it and about what year? _____
- ❑ Cardiomyopathy
- ❑ Atrial fibrillation
- ❑ Pacemaker/Defibrillator implant; If so, where did you have it and about what year?_____
- ❑ CHF (congestive heart failure)
- ❑ Peripheral Arterial Disease
- ❑ Cancer; If so, what type_____
- ❑ Diabetes
- ❑ Stroke
- ❑ Other _____

Alcohol Use: ❑ YES ❑ NO
Are you a smoker: ❑ YES ❑ NO
Electronic Cigarette/ Vaping: ❑ YES ❑ NO
Substance abuse: ❑ YES ❑ NO

EMPLOYMENT/SCHOOL:

- ❑ Employed
- ❑ Part Time
- ❑ Retired
- ❑ Disabled
- ❑ Unemployed
- ❑ Student
- ❑ Unemployed

Home/Environment

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed

EXERCISE:

- ❑ FREQUENCY:
  - ❑ Never
  - ❑ Daily
  - ❑ 1-2 times a week
- ❑ EXERCISE TYPE:_____