



Naugatuck Valley Cardiovascular Associates, LLC

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PATIENT MEDICAL HISTORY

Section A: Patient Demographics

Patient Name: _____ Today's Date: _____

Patient DOB: _____ Gender: M ☐ F ☐

Occupation: _____ How long at this type of work: _____

Name and location of Pharmacy: _____

Pharmacy Phone # _____

Section B: Medical Information

Do you have an Advanced Directive (e.g., Do Not Resuscitate Order) NO ☐ YES ☐ Specify: _____

Are you on a special or restricted diet? ☐ NO ☐ YES Specify: _____

Females Only: Are you currently pregnant or trying to get pregnant? ☐ NO ☐ Yes Due date: _____

What special equipment or devices do you use at home? _____

Do you have home care services or agency services? _____

Section C: Tobacco/Substance Use

Do you smoke? ☐ NO ☐ YES If yes type of tobacco used: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco

If yes, how long have you smoked? _____ Amount daily _____

Have you ever smoked in the past? ☐ NO ☐ YES For how long did you smoke? _____ # of years Quit _____

Do you drink alcohol? ☐ NO ☐ YES If yes, how often? _____ How many drinks daily? _____

Section D: Allergies

Are you allergic or sensitive to any medications? ☐ NO ☐ YES

Specify: _____

Are you allergic or sensitive to any foods? ☐ NO ☐ YES

Specify: _____

Are you allergic to latex? ☐ NO ☐ YES Specify: _____

Are you allergic to dyes used for Xrays? ☐ NO ☐ YES Specify: _____

Are you allergic to iodine or seafood? ☐ NO ☐ YES Specify: _____