KAUFMAN & ZINSMEISTER, M.D., P.A.

2900 LINDEN LANE, SUITE 200 ♥ SILVER SPRING, MARYLAND 20910 ♥ (301) 587-7040

PATIENT MEDICAL HISTORY

Please print. All information will be confidential.

Today's Date: _____ Account No.: _____

Patient Name: _____ Sex: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____

What medical problem or condition are you here to have evaluated?

_____

Allergy

1. Are you allergic to any medications? (If yes, complete #5) ☐ YES ☐ NO
2. Are you allergic to any seafood or iodine? ☐ YES ☐ NO
3. Can you tolerate Aspirin? ☐ YES ☐ NO
4. Have you ever had an allergic reaction to I.V.P. dye? ☐ YES ☐ NO
   (Intravenous pyelogram or gallbladder dye)
5. Please list every drug and substance that causes an allergic reaction:
   a. _____ c. _____
   b. _____ d. _____

Medications

Please list all the medications (prescribed and over the counter) that you are currently taking. Indicate the dosage and times per day.

a. _____ e. _____
b. _____ f. _____
c. _____ g. _____
d. _____ h. _____

Surgery

Please list all surgical procedures that you have had and their dates:

a. _____ c. _____
b. _____ d. _____

Activity Level

Which of the following describes your level of physical activity both in your daily life as well as in your leisure time:

- ☐ Exercise strenuously on a regular basis
- ☐ Exercise moderately on a regular basis
- ☐ Exercise on an occasional basis
- ☐ Do not regularly exercise, but have an active lifestyle
- ☐ Have difficulty accomplishing light chores of daily living
- ☐ Require assistance to accomplish self-care

Patient Name: _____ **Account No:** _____

Personal Medical History

1. Have you ever had any of the following?
    a. High blood pressure? ☐ YES ☐ NO
    b. Tobacco Use? ☐ YES ☐ NO
    c. Diabetes? ☐ YES ☐ NO
    d. Gout? ☐ YES ☐ NO
    e. High blood cholesterol or triglycerides? ☐ YES ☐ NO
    f. Cancer? ☐ YES ☐ NO
    g. Rheumatic fever involving the heart? ☐ YES ☐ NO
2. Do you drink alcohol on a regular basis? ☐ YES ☐ NO
    --If no, did you drink heavily in the past? ☐ YES ☐ NO
3. Have you ever been treated for substance abuse? ☐ YES ☐ NO

Family History

Please list which family members (blood relatives) have experienced these conditions.

Heart Attack _____ age: _____
_____ age: _____
_____ age: _____
Stroke _____ age: _____
_____ age: _____
_____ age: _____
Sudden Death _____ age: _____
_____ age: _____

Aneurysm: _____
Diabetes: _____
Cancer: _____
High Blood Pressure: _____
High Cholesterol: _____
Heart Failure: _____
Arteriosclerosis: _____
(hardening of the arteries)

If either of your parents is deceased, please indicate the cause of death and age of death:

Father: _____ Age: _____
Mother: _____ Age: _____

Personal Cardiac History

1. Have you ever had?
    a. An electrocardiogram (EKG)? ☐ YES ☐ NO
    b. A chest x-ray? ☐ YES ☐ NO
    c. An echocardiogram? ☐ YES ☐ NO
    d. A treadmill stress test? ☐ YES ☐ NO
    e. A cardiac catheterization? ☐ YES ☐ NO
    f. A coronary angioplasty/cardiac stent? ☐ YES ☐ NO
    g. A temporary or permanent pacemaker? ☐ YES ☐ NO
    h. A Holter monitor? ☐ YES ☐ NO

Do you have any other special concerns or additional information we should be aware of regarding your care?

_____
_____

I certify that to the best of my knowledge the above information is correct.

Signature _____ Date _____