James J. Buonavolonta, M.D., P.A. Cardiac Imaging Center

New Patient Medical Information Form

Date:___________

NAME: ____ **PHONE:** _________________________

ADDRESS ____

SEX: M☐ **F**☐ **DOB:**__________ **AGE:**_____ **Height:**__________ **Weight:**_________

Females: Breast Size:___________________________ **(Required for Imaging Quality purposes)**

REFERRED BY: ____

ALLERGIES: ____

REASON FOR VISIT: ____

PRESENT COMPLAINTS (Please check "Yes" or "No")

YES	NO		
☐	☐	CHEST DISCOMFORT	HOW LONG? ______________________
☐	☐	SHORTNESS OF BREATH	HOW LONG? ______________________
☐	☐	ANKLE SWELLING	HOW LONG? ______________________
☐	☐	PALPITATIONS	HOW LONG? ______________________
☐	☐	LIGHTHEADEDNESS/FAINTING	HOW LONG? ______________________
☐	☐	LEG CRAMPS WITH WALKING	HOW LONG? ______________________
☐	☐	RECENT ER VISIT	WHERE/WHEN/WHY? ______________________
☐	☐	RECENT HOSPITALIZATION	WHERE/WHEN/WHY? ______________________

HAVE YOU HAD HEART TESTING DONE ANYWHERE ELSE? (ECHO, STRESS TEST ETC.)
IF SO, WHERE and WHEN? NOTE: **Please Bring Copies If Possible**

MEDICATIONS

Medication Name	Dose	How Often Taken?

MEDICAL HISTORY

YES	NO	
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HEART ATTACK. WHEN? ________
☐	☐	PREVIOUS HEART DISEASE OR PROBLEM. WHAT TYPE? _________
☐	☐	HEART CATHETERIZATION. WHEN? _________
☐	☐	HEART FAILURE. WHEN? ________
☐	☐	IRREGULAR PULSE
☐	☐	HEART MURMUR
☐	☐	STROKE
☐	☐	HIGH CHOLESTEROL
☐	☐	DIABETES
☐	☐	THYROID PROBLEMS
☐	☐	LUNG PROBLEMS
☐	☐	GASTROINTESTINAL PROBLEMS
☐	☐	RHEUMATIC FEVER
☐	☐	ANEMIA
☐	☐	ARTHRITIS
☐	☐	SEIZURES
☐	☐	CANCER
☐	☐	BREAST SURGERY (INCLUDING IMPLANTS)

PAST MEDICAL HISTORY

ILLNESSES:____

OPERATIONS:____

SOCIAL HISTORY

OCCUPATION:_________________________ MARITAL STATUS:______________________________

DO YOU EXERCISE? TYPE/FREQUENCY?____

TOBACCO USE: YES ☐ NO ☐ PAST ☐

TYPE: CIGS ☐ CIGARS ☐ CHEWING ☐

CAFFEINE USE: YES ☐ NO ☐

ALCOHOL USE: YES ☐ NO ☐ PAST ☐

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FAMILY HISTORY OF HEART ATTACK OR STROKE

Member:____________________ **Heart Attack:**______ **Stroke:** _______ **Age of Occurrence:** _____

Member:____________________ **Heart Attack:**______ **Stroke:** _______ **Age of Occurrence:** _____

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Member:____________________ **Heart Attack:**______ **Stroke:** _______ **Age of Occurrence:** _____

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Member:____________________ **Heart Attack:**______ **Stroke:** _______ **Age of Occurrence:** _____

PREVIOUS PHYSICIANS

Primary Care Physician:________________________**PHONE:**_________________**FAX:**____________________

Cardiologist:__________________________________ **PHONE:** __________________**FAX:**__________________

What recent testing have you have done?____

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