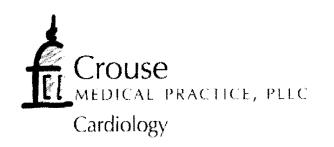
Joseph G. Battaglia, M.D., F.A.C.C James A. Longo, M.D., F.A.C.C. Matthew E. Gorman, M.D., F.A.C.C. Anil K. George, M.D., F.A.C.C. Jennifer Lynch, P.A.C Edward Golash, P.A.C. Anna Buckman, M.S.N.,R.N.,N.P.



William P. Berkery, M.D., F.A.C.C. Kwabena A. Boahene, M.D., F.A.C.C. Jeffrey D. Ascenzo, M.D., F.A.C.C. Fafa K. Xexemeku, M.D. Rebecca Boyea-Kertesz, P.A.C. Kayc McHone, P.A.C. Courtney Eggleston, P.A.C.

Pre-Examination Information

Patient Name		Dat	Date of Birth:		Date of Appointment:	
Reaso	on you are seeing a he	eart specialist:	HARLING CO. C.			
	Planca list on		ealth History	owe vev be		
Ds		fillness or surgery	lizations or operati Name of Ho		Location of Hospital	
	i ype o	miness or surgery	italie of no	apital	Location of Hospital	
(Check the box if	you have now	or have ever had	d any of t	he following	
		conditi	ions/illnesses:			
	Cancer: Type			50		
	Unexplained fevers Prolonged fatigue	☐ Stroke☐ Diabetes	□ Liver Disease□ Arthritis	☐ Osteo	•	
	Abnormal chest x-ray		☐ Gout		ic bronchitis	
	Rheumatic fever	☐ Depression		☐ Seizures or Epilepsy		
	Kidney disease	☐ Chest pain			lood pressure	
	Stomach ulcers	□ Pneumonia	☐ Heart Murmur	_	ic lung disease	
	Heart disease	☐ Heart attack	☐ Hepatitis		te disease	
	Thyroid disease	□Anxiety/Panic	attacks	□ Sleep	Apnea	
	Blood, albumin (prote	in) or sugar in urir	ne			

Please list present medications with dosages and how taken. Please bring all medications with you to your appointment.

Name of Medication	Dosage	How Taken					
VIII VIII VIII VIII VIII VIII VIII VII							
	10000	300					
Davis and a second seco		Accession 2. After a Book hadroom					
Do you use non-prescription medication	is, diet supplements, or Vi	tamins? If so, list below:					
		117 - 12411 - 12211 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221 - 1221					
Do you have allergies to any medications? If so, list below:							
bo you have allergies to any medications: It so, list below.							

Family Health History
Present Health, or if deceased, cause of death

	Age	Present Health, or if	deceased, cause of death	Age of deat
Mother				
Father				
Brother(s)				
Sister(s)				
Children			Anna and an anna an a	
Please place	the appropriat	e letter in the space to ir had any of the followi	ndicate if blood relatives ha	ave and /or hav
M -mother	F -father	S-sister B-bro	ther G -grandparent	C -children
Heart dis	ease	Depression	Crippling arthritis	Lupus
Suicide a	ttempt	Lung cancer	Nervous breakdown	Stroke
High bloc	od pressure	Cervical cancer	Glaucoma	Gout
High cho	lesterol	Breast cancer	Seizures/fits	Epileps
Thyroid p	roblems	Sudden death	Uterine cancer	Cancer
Bleeding disorder		Colon cancerNervous disorder		Diabete
Sickle cel	l disease	Alcoholism	Kidney disease	Leukem
Cardiac stress t Cardiac cathete	est/echo erization		te the place and year perfo	
			Employer	

Check areas below that relate to your current health status:

Check areas below that relate to your	1		
Review of systems	Yes	No	Comment/Explanation
General Health (Do you feel well?)			
Women: Post Menopausal			
Irregular bleeding			
Normal periods			
Heartburn, belching, nausea, bloated stomach,			
or difficulty swallowing? If yes, please explain.			
Loss of appetite? More than a 5 pound weight			
change in the last year?			
Abdominal pain, pressure, or discomfort?			
Change in bowel habits?			
Urinary problems (pain, burning or frequency)?			
Incontinence?			
Headaches, dizziness, loss of consciousness, or			
poor memory?	a di constante		
Chest pain or shortness of breath, at rest or with			
exertion? Irregular or pounding heartbeat?			
Difficulty breathing, cough, or lung congestion?			
Changes in eye sight or eye pain?			
Loss of hearing? Ear or sinus pain? Ringing or			
buzzing in ears?			
Changes in self breast exam?			
Rash, skin discoloration or changes in birthmarks			
or moles?	in the state of th		
Bruising or bleeding?			
Bone or joint pain, muscle aches or loss of			
strength?			
Increased thirst, fatigue, loss of hair or dry skin?			
Swelling in neck, armpit, or groin?			
Depression or anxiety? Trouble sleeping?			
Allergies (food, drug or environmental)?			
Do you: Smoke?			
Drink alcohol?	니		
Drink caffeine?			
Use marijuana, cocaine, or other			
street drugs?			
Do you follow a special diet?		П	
Do you add salt at the table?			
Other:			
Signature of Patient			Date
Reviewed by			Date