BSW Arrhythmia Group
ADULT PATIENT INFORMATION

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENCE AND WILL NOT RELEASE WITHOUT SIGNED CONSENT. It may be sent to consultants, if referred.

NAME: _____ **DATE:** ___/___/___
LAST FIRST M.I.

BIRTH DATE: ___/___/___ **AGE:** _____ **GENDER:** M / F

PREFERRED PHARMACY:
NAME PH. NUMBER

PREVIOUS PHYSICIAN:
NAME PH. NUMBER

MEDICAL CONDITION(S) / HOSPITALIZATIONS: (Example: Diabetes, High Blood Pressure, Asthma...)

_____
_____
_____
_____
_____

ALLERGIES: (Medications, Food, Insects)

SURGERIES: (Example: Tonsillectomy, Gallbladder, Hernia Repair...)

TYPE OF SURGERY	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS: (Please include vitamins and herbals)

	DRUG	DOSE	HOW MANY TIMES PER DAY?
Ex:	Advil	200mg	3 times per day
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

WOMEN'S HEALTH: **LAST MENSTRUAL CYCLE:** ___/___/___

NUMBER OF PREGNANCIES: _____
NUMBER OF MISCARRIAGES: _____
NUMBER OF CHILDREN: _____
LAST PAP SMEAR: _____
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? Y / N
LAST MAMMOGRAM (if over age 40): _____
LAST BONE DENSITY TEST (if after menopause): _____

MEN'S HEALTH:

LAST TESTICULAR EXAM: _____
LAST PROSTATE EXAM (if over age 50):

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LAST FIRST M.I.

LAST COLONOSCOPY (if over age 50): _____
LAST TETANUS SHOT: _____
LAST FLU SHOT: _____
RECEIVED ALL 3 DOSES OF HEPATITIS B VACCINE? Y / N
HAD CHICKEN POX AS A CHILD OR THE LIVARICELLA VACCINE? Y / N
Date (or approximate if known): ___/___/___

OCCUPATION(S):

MARITAL STATUS: Single Married Divorced Separated Widowed

SEXUAL ORIENTATION: Heterosexual Homosexual Bisexual Trans-sexual

HOW WOULD YOU CLASSIFY YOUR NUTRITION? Excellent Good Fair Poor

EXERCISE REGULARLY? Y / N
TYPE: _____ TIMES PER WEEK: ____ HOW LONG?____(min)

TOBACCO USE CURRENTLY? Y / N
IF YES, # PACKS PER DAY_____ FOR HOW MANY YEARS? _____
TOBACCO USE IN THE PAST? Y / N
IF YES, WHEN DID YOU QUIT? _____ HOW MANY YEARS DID YOU SMOKE?_____

ALCOHOL USE? Y / N **ALCOHOL USE IN THE PAST?** Y / N
NUMBER OF DRINKS PER DAY? _____
TYPE OF ALCOHOL? (Ex: beer, vodka, cocktails?) _____

DRUG USE CURRENTLY? Y / N **DRUG USE IN THE PAST?** Y / N
TYPE OF DRUGS? (Ex: marijuana, cocaine, heroin?) _____
HAVE YOU EVER INJECTED YOURSELF WITH DRUGS? Y / N

CAFFEINE USE? Y / N
HOW MANY CUPS OF COFFEE PER DAY? _____
NUMBER OF SODAS PER DAY? _____

DO YOU WEAR YOUR SEATBELT? Y / N
DO YOU OWN A FIREARM? Y / N

FAMILY HISTORY: (Please list medical conditions that run in your family. For example: heart attack, stroke, high blood pressure, high cholesterol, cancer, depression, etc...)

	CONDITION(S)	LIVING?
FATHER:	_____	Y / N
MOTHER:	_____	Y / N
BROTHER(S):	_____	Y / N
SISTER(S):	_____	Y / N
GRANDPARENTS:		
MATERNAL:	_____	Y / N
PATERNAL:		Y / N