Naugatuck Valley Cardiovascular Associates, LLC
George V. Antonopoulos, M.D. Suphichaya Muangman, MD
1625 Straits Turnpike, Suite 209, Middlebury, CT 06762 Ph: 203-758-9100 Fax: 203-758-9400

Other Locations: 205 So. Main St. Thomaston, CT 06767 | 22 Old Waterbury Rd Southbury, CT 06488 | 385 Main Street So. Southbury, CT 06488 | 503 Wolcott Rd. Wolcott, CT 06705

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 Resucitate 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:_____

Patient Name:_____

Section E: Exercise Tolerance

Describe your regular exercise tolerance:

☐Regular Exercise no limitations ☐Active (over 2 flights of steps or comparable, with ease)

☐Moderate (1-2 flights of steps or comparable, with ease) ☐Limited (less than 1 flight of steps)

☐Able to walk with assistance (cane, walker) ☐Unable to walk, wheelchair bound or bedridden

Comments:_____

Section F: Medical History of Heart Disease – Do you have a history of:

☐High Blood Pressure Medication?_____

☐Chest Pain ☐With Activity ☐At rest Comments:_____

☐Chest Pain combined with: ☐Difficulty Breathing ☐Sweatiness ☐Nauseated feeling

Comments:_____

☐Numbness and or tingling – if so, where?_____

☐Shortness of Breath At Rest ☐ With Exercise ☐ Comments:_____

☐Heart Attack Date:_____

☐Heart Surgery Date:_____ ☐Angioplasty/Stent Date:_____

☐Heart Rhythm problem or palpitations Describe:_____

☐Pacemaker or Internal Cardiac Defibrillator Type:_____Date last checked:_____

Who monitors your pacemaker checks?_____

☐Heart valve problem or congenital abnormality Describe:_____

Are you currently being treated for this?_____

☐Congestive Heart Failure or fluid in your lungs Describe:_____

Are you currently being treated for this?_____

Section G: Other Medical Conditions – Do you have a history of:

☐Kidney Disease ☐Dialysis ☐Kidney Transplant ☐Kidney Surgery (specify)_____

☐Bladder/Urinary disorder(s) including infections (specify)_____

☐Adrenal Disease Specify:_____

☐Stomach ulcers ☐Hiatal hernia (repair?_____) ☐Unable to lie flat without heartburn

☐Fainting spells and/or syncoopal episodes

☐Diabetes How is it controlled? ☐Insulin ☐Pills ☐Diet Comments:_____

☐Thyroid Are you on Thyroid medication? _____

Section G cont'd: Other Medical Conditions

☐Neurologic Disease ☐Parkinson's Disease ☐Seizures ☐Stroke – Date:_____

Are you on any medications for the above conditions?_____

☐Asthma/Wheezing ☐Emphysema ☐COPD ☐Sleep Apnea ☐Tuberculosis ☐Other_____

☐Excessive Bleeding ☐Currently taking or history of taking blood thinning medications (Coumadin, Lovenox)

☐Taking aspirin or aspirin containing medications

☐Blood Clots (legs or Lungs) – Specify _____

☐Hepatitis Specify type and treatment:_____

☐HIV + Date:_____Any treatement?_____

☐Any other illness – Specify:_____

_____

Section H: Family History

Family history of:	Mother	Father	Siblings	Brother/Sister/Comments
Coronary Artery Disease	Y N	Y N	Y N	_____
Congestive Heart Failure	Y N	Y N	Y N	_____
Diabetes	Y N	Y N	Y N	_____
Heart Attack	Y N	Y N	Y N	_____
Heart Surgery	Y N	Y N	Y N	_____
Hypertension	Y N	Y N	Y N	_____
Hyperlipidemia	Y N	Y N	Y N	_____
Stroke	Y N	Y N	Y N	_____

_____ _____

Patient Signature Date

Person completing this form, if other than patient:_____

Relationship:_____

Signature:_____Date:_____