O'CARROLL & ASSOCIATES, L.L.C.

PATIENT NAME: _____

CHIEF COMPLAINT: (please describe location and duration) _____

_____

_____

PERSONAL HISTORY

HAVE YOU EVER HAD (PLEASE CIRCLE YES OR NO)

1. Surgery requiring anesthesia……..YES or NO
2. Any joint replacement……..YES or NO
3. Any valve replacement……YES or NO
4. Any ill effects related to an anesthetic……..YES or NO
5. Fainting spells……YES or NO
6. Seizures or convulsions……YES or NO
7. Stroke……..YES or NO
8. Depression or mental illness……YES or NO
9. Thyroid problems……YES or NO
10. Chronic or frequent coughs……YES or NO
11. Shortness of breath……YES or NO
12. Asthma or hay fever……YES or NO
13. Lung disease (pneumonia, TB, bronchitis)……YES or NO
14. High blood pressure……YES or NO
15. Rheumatic fever or heart disease……YES or NO
16. Rheumatoid arthritis……YES or NO
17. Heart attack……YES or NO
18. Pacemaker or defibrillator……YES or NO
19. Chest pain……YES or NO
20. Palpitation or fluttering heart……YES or NO
21. Bleeding tendencies……YES or NO
22. Diabetes Type 1 or Type 2……YES or NO
23. Jaundice or liver disease……YES or NO
24. Blood clotting in lungs or legs……YES or NO
25. Infectious disease of any kind……YES or NO
26. Blood clotting in lungs or legs……YES or NO
27. Infectious disease of any kind……YES or NO
28. Colitis, gastritis, GERD……YES or NO
29. Bladder, kidney disease……YES or NO
30. Cancer……YES or NO
31. Hepatitis-type _____……YES or NO

HABITS	NEVER	OCCASIONALLY	DAILY
32. Street drugs	_____	_____	_____
33. Alcohol	_____	_____	_____
33. Tobacco	_____	_____	_____
Cigarettes	_____	_____	_____
Cigars	_____	_____	_____
Pipe	_____	_____	_____
Caffeine	_____	_____	_____

ALLERGIES

34. Any drug allergies……YES or NO
If "yes" specify _____

35. Any environmental/food allergies……YES or NO
If "yes" specify _____

PLEASE LIST CURRENT MEDICATIONS

_____

_____

_____

_____

36. Do you see a Cardiologist?……YES or NO
37. If you see a Cardiologist, who is it? _____
37. Do you take aspirin……YES or NO
38. Do you take any supplements……YES or NO
39. Do you take Coumadin or Plavix……YES or NO
40. Do you take "Blood Thinners" of any type……YES or NO
If "yes" please specify _____

FAMILY HISTORY

PLEASE ANSWER WITH A YES OR NO IF ANYONE IN YOUR FAMILY HAS ANY OF THE FOLLOWING:

1. Alcoholism……YES or NO
2. Allergies/Hay fever……YES or NO
3. Anemia……YES or NO
4. Anxiety……YES or NO
5. Asthma……YES or NO
6. Atrial fibrillation……YES or NO
7. Cardiovascular disease……YES or NO
8. Cirrhosis/Liver disease……YES or NO
9. Colitis/bowel……YES or NO
10. Cancer……YES or NO
11. COPD/Lund disease……YES or NO
12. CRF (Kidney disease/failure)……YES or NO
13. DVT (Clotting in legs)……YES or NO
14. Depression……YES or NO
15. Type 1 diabetes……YES or NO
16. Type 2 diabetes……YES or NO
17. Epilepsy……YES or NO
18. Gastrointestinal Disease……YES or NO
19. Heart Murmur……YES or NO
20. Hepatitis……YES or NO
21. High blood pressure……YES or NO
22. Kidney infections……YES or NO
23. Kidney stone……YES or NO
24. Migraine……YES or NO
25. Osteoarthritis……YES or NO
26. Osteoporosis……YES or NO
27. Neurological disease/disorder……YES or NO
28. Pulmonary disease……YES or NO
29. Rheumatoid arthritis……YES or NO
30. Thyroid disease……YES or NO

Signature: _____ **Date:** _____