**Healthy Heart Cardiology**

**Intake Paperwork**

*Complete to the best of your ability*

**Name: h h Date of Birth: hh**

**Age: h h Sex: h h Primary Care: ­­­­­ h h**

**Address: h h**

**Home Phone: h h**

**Cell Phone: hh**

**Work Phone: hh**

**E-Mail: h h**

**Occupation: h h Full Time / Part Time**

**Employer: h h Education Level: hh**

**Marital Status: h Spouse/Partner Name: h h**

**Children’s Name and Year of Birth: Jjjjjjjjjjjjjj jjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjj jjjjjj**

**jjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjj**

**Are you sexually active: Yes hh No hh Form of Birth Control: h h**

**Have you ever used tobacco? Yes hh No hh**

**Are you currently using tobacco? Yes hh No hh**

**If yes, what kind and how much/often? Jjjjjjjjjjjjjjjjj jjjjjjjjjjjjjjj jjjjjjjjjjjjjjj**

**jjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjj**

**Do you drink alcohol? Yes hh No hh How often? H h**

**Do you use recreational drugs (includes marijuana)? Yes hhNo hhh In the past hh**

**If yes, what kind and how much/often? Jjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjj**

**jjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjjj**

**How many hours of sleep a night do you get? h hh hours**

**Do you have issues falling asleep? Yes hh No h Staying asleep? Yes hNo hh**

**Are you allergic to any medication? Yes hhh No hhh Unknown hhh**

**If yes, which medication? Uiugi;kjbk;ivkhvvvvvvvvvvvvvvvvvvvvvvvvvvvvvv**

**hggfjgfjfvjfhjgggggggggggggggggggggggggggggggggggggggggggggggg**

**Please list all supplements/vitamins/medications taken over the counter:**

**jfgkhfjjjjjjjjjjjjjjjhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**

**Please list all medications taken with their strength and frequency:**

**jfgkhfjjjjjjjjjjjjjjjhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**

**Please List all surgical history with dates:**

1. **Hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**
2. **Hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**
3. **Hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**
4. **Hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**
5. **Hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**
6. **Hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**

**Do you have any current medical diagnosis’ or past medical history?**

**Yes hhh No hhh If yes please list: hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**

**Hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh gghhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**

**Please list any known medical history for all immediate family members with their name and roughly their age at the time they received the diagnosis if known:**

**hhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhhh**

**Emergency Contact Name: h vvvvvvvvvvvvvvvvcvvvv h**

**Emergency Contact Phone Number: h h**

**What is your relationship? *(spouse, parent, son, etc.)* ggghggggggggggggggggg**

**Preferred Pharmacy Name: h h**

**Preferred Pharmacy Location: h h**