Complete Cardioascular Center

Dr. Emile Barrow Dr. Mark Napoli Dr. James Rittelmeyer

Patient Name: _____ Date of Birth: _____

Referring Doctor: _____

Chief Complaint for this visit: _____

MEDICATIONS - ATTACH LIST IF NEEDED

Name	Strength	Frequency

PREFERRED PHARMACY: _____

ALLERGIES ☐ no known allergies

TOBACCO USE

☐ Former Smoker
☐ Never a Smoker
☐ Current everyday smoker
☐ Current someday smoker

ALCOHOL USE

☐ Yes
How much: _____
☐ No

PAST MEDICAL HISTORY (diseases/illnesses)

PAST SURGICAL HISTORY

FAMILY HISTORY

	MOTHER	FATHER
Diabetes	☐	☐
Hypertension	☐	☐
Coronary Artery Disease	☐	☐
Stroke	☐	☐
Sudden Death	☐	☐

RECENT HOSPITALIZATION (in the last 3 months)

If yes, please list the hospital(s) below

LIST ANY PLANNED SURGERIES (to be performed within the next 3 months)

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