Stuart Fischer, MD, FACC, FACP, FSCAI, CCDS
Timothy O'Neill, MD

Steven T. Forman, MD, FACC, FSCAI, RVT
Bret A. Witter, MD, FACC, FACP

Ramandeep K. Brar, MD, FACC, FHRS
Robert S. Lee, MD

PATIENT HISTORY FORM

Name: ______________________________ Date: ____ /____ /____

Reason for your visit today: ______________________________

____

PAST MEDICAL HISTORY

Medical Problems: ______________________________

____

____

Operations: ______________________________

____

____

Allergies to Medications: ______________________________

____

____

Medications You Are Now Taking: ______________________________

____

____

SOCIAL HISTORY

Smoke: ______________________________

____

Alcohol: ______________________________

____

Occupation: ______________________________

Change in Weight Recently: ______________________________

MEDICAL HISTORY IN FAMILY

Father: ______________________________

Mother: ______________________________

Brothers: ______________________________

Sisters: ______________________________

Grandparents: ______________________________

Others: ______________________________

5300 Katella Avenue | Los Alamitos, CA 90720 | Tel (562) 430-7533 | Fax (562) 430-8055

SYMPTOM REVIEW

PLEASE MARK THE APPROPRIATE BOX

SYMPTOM	NEVER	SOMETIMES	FREQUENTLY
Chest Pain	☐	☐	☐
Shortness of Breath at Rest	☐	☐	☐
Shortness of Breath with Exercise	☐	☐	☐
Ankle Swelling	☐	☐	☐
Palpitation	☐	☐	☐
Cough	☐	☐	☐
Phlegm (Mucus)s	☐	☐	☐
Cough Blood	☐	☐	☐
Indigestion	☐	☐	☐
Vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Blood in Stool	☐	☐	☐
Black Stool	☐	☐	☐
Painful or Bloody Urine	☐	☐	☐
Vaginal Bleeding (Females)	☐	☐	☐
Slow Urinary System	☐	☐	☐
Arthritis	☐	☐	☐
Paralysis	☐	☐	☐
Tingling in Arms / Legs / Both	☐	☐	☐
Leg Cramps	☐	☐	☐
Seizures	☐	☐	☐
Easy Bruising	☐	☐	☐

Name: ______________________________ Date: _______ /_______ /_______
(SIGNATURE)