Randolph Health
Heart & Vascular Institute
Powered by Novant Health

Adult History-1

Patient's Name _____ Male / Female Date of Birth _____

Referring Doctor/Primary Care Doctor_____

Reason for Appointment today_____

CURRENT MEDICATIONS (Name of prescription and over the counter medications & dosage)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you take any:

□ Herbal Products
□ Vitamins
□ Minerals
□ Aspirin

ALLERGIES & REACTIONS □ No known Allergies **LOCAL PHARMACY:**_____

Drugs _____

Food _____ Other _____

PAST MEDICAL & FAMILY HISTORY (Please check if you or your family members have had any of the following diseases)

	Self	Father	Mother	Grandparent (Maternal)	Grandparent (Paternal)	Brother	Sister
Diabetes	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□
Heart Attack	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□
Asthma/Emphysema/COPD	□	□	□	□	□	□	□
Breast Cancer	□	□	□	□	□	□	□
Colon Cancer	□	□	□	□	□	□	□
Prostate Cancer	□	□	□	□	□	□	□
Other Cancer _____	□	□	□	□	□	□	□
Other Illness _____	□	□	□	□	□	□	□
Kidney/Bladder Problems	□	□	□	□	□	□	□
Thyroid Disease	□	□	□	□	□	□	□
Hepatitis or Jaundice	□	□	□	□	□	□	□
Anemia	□	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□	□
Positive HIV/AIDS	□	□	□	□	□	□	□
Seizure Disorder	□	□	□	□	□	□	□
DVT	□	□	□	□	□	□	□
Bleeding Problems	□	□	□	□	□	□	□
A-fib	□	□	□	□	□	□	□
Blood Clots	□	□	□	□	□	□	□
Pulmonary Embolism	□	□	□	□	□	□	□
Irregular Heartbeat	□	□	□	□	□	□	□

Patient Name _____ Patient DOB _____

PAST SURGERIES (Please list all past surgeries and the year performed)

□ Appendix _____ year □ Gallbladder _____ year □ Thyroid _____ year □ Hysterectomy _____ year

□ Hernia _____ year □ Heart _____ year □ Lung _____ year □ Tonsillectomy _____ year

Other _____

_____

_____

_____

RECENT HOSPITALIZATIONS (Other than above surgeries or child birth)

Year	Reason	Year	Reason

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed Number of Children: _____

Employment: □ Full-time □ Part-time □ Disabled □ Retired □ Unemployed

Occupation _____

How often do you exercise: □ None □ 1-2 days/week □ 3-4 days/week □ 5+ days/week

Caffeinated Beverages: Cups/glasses per day_____

TOBACCO & ALCOHOL HISTORY

Tobacco:

Do you use now? □ Yes □ No Type _____ Would you like to quit? □ Yes □ No

Have you used in the past? □ Yes □ No How many years did you use? _____ When did you quit? _____

Alcohol:

How much alcohol do you drink? □ None □ Rarely □ 1-7 drinks/week □ 8-14 drinks/week □ more than 14/week

Have you had a problem with alcohol in the past? □ Yes □ No

Recreational Drugs:

Do you currently use recreational drugs? □ Yes □ No If so, type: _____

Previous Drug Use/Addiction □ Yes □ No If so, type: _____

Are you in a Rehab or Alcohol recovery program? □ Yes □ No If so, type:

_____

IF YOU HAVE A LIVING WILL OR HEALTHCARE POWER OF ATTORNEY, PLEASE PROVIDE US WITH A COPY.