Kern Cardiology Medical Group

-Since 1978

(Sam) Sarabjit Singh, MD. FACC. FSCAI

New Patient Health Questionnaire (Confidential) **Date: _____**

(Please provide all the information asked to get the most effective treatment)

Patient Name:_____Birth Date: __/___/_____

Referring Doctor_____ PCP: _____

What brings you to our office today? _____

_____

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Are you allergic to: □Iodine □ Shellfish □ Aspirin □ Tape □Latex □ Other _____
Do you have any medication allergies? □ No. □ Yes. _____
Do you have any food allergies? □ No. □ Yes. _____
Are you currently on coumadin? □ No. □ Yes. Who follows? _____

I. Symptoms: Please check any symptoms from the list below that you have, so we can find out more about it:

☐	Angina	☐	Arrhythmia	☐	Abnormal EKG
☐	Sleep Apnea	☐	_____Bleeding	☐	Dizziness/Syncope
☐	Chest Pains/Pressure	☐	Diabetes (I) (II)	☐	Kidney Disease
☐	Enlarged Heart	☐	Fainting	☐	Heart Murmur
☐	Heart Attack	☐	High Blood Pressure	☐	Rheumatic Fever
☐	Heart Failure	☐	High Cholesterol	☐	Blue lips or /finger nails
☐	Leg Cramps (walking)	☐	Leg Swelling	☐	Palpitations
☐	Lung Disease	☐	GERD (reflux/indigestion)	☐	Shortness of Breath
☐	Swollen Legs	☐	Sexual Dysfunction	☐	Stroke /TIA
☐	Thyroid Disease	☐	Menopause	☐	HIV/AIDS

Other symptoms: _____
_____

II. Previous Testing/Procedures: Please check any tests from the list below that you have had before, we can request a copy of recent report:
Where_____ When_____

☐	Stress test	☐	Angiogram	☐	Angioplasty
☐	Ablation	☐	EKG/ECG	☐	Holter Monitor (24-48hrs)
☐	__Days Event Monitor	☐	Carotid Ultrasound	☐	Echocardiogram
☐	Lower Extremity Doppler	☐	Thallium test	☐	Pacemaker
☐	Defibrillator	☐	Coronary CTA (CAT scan)	☐	Stress Test
☐		☐		☐	

III. Social History: Please respond TRUTHFULLY to the following questions:

	Type	Past or Current	Amount
Alcohol			
Caffeine			
Energy Drinks			
Exercise			
Herbal			
Tobacco/Smoking			
Hobby			

IV. Personal Surgical History:

	Y/N	When (mm/dd/yy)	Complications(Y/N)
Appendectomy			
Bypass surgery			
Valve surgery			
Back surgery			
Gallbladder surgery			
Hysterectomy			
Knee surgery			
Thyroidectomy			
Other:			

V. Family Medical History:

	Father	Mother	Sister	Brother
Coronary Artery Disease				
Diabetes (type I) or (type II)				
High Blood Pressure				
High Cholesterol				
Obesity				
Stroke / CVA				
Sudden Death				
_____Cancer				
Other:				

Pharmacy Name:

Address:_____ _____
Phone #