ENGLEWOOD HEALTH
PHYSICIAN NETWORK

Cardiovascular Consultants of New Jersey
Health History

Today's Date: ____/_____/____ Patient's Name: _____ DOB: _____

Occupation: _____

Do you have a living will? _____ If yes, can a copy be provided? _____

Who is your health care representative? _____

PATIENT SOCIAL HISTORY: What is your approximate daily intake of the following?

Cups of Coffee/tea_____ Alcohol_____ Tobacco_____

Have you smoked in the past?_____

Previous hospitalizations/surgeries/serious illnesses:

_____
_____
_____
_____
_____

Current list of medications (over-the-counter and vitamins, etc.)

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History

Is there a family history of heart disease, high blood pressure, high cholesterol, diabetes or other serious illness? YES / NO
If so, please list below:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
Others	_____	_____	_____

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Allergies:

Are you allergic to shellfish, IV dyes, iodine, or medications? Yes ☐ No ☐

If so, please list below:

_____

_____

Review of Systems: Please indicate any personal history below:

	Now	Never	Past
Cardiovascular			
Shortness of breath	☐	☐	☐
High cholesterol/Fats	☐	☐	☐
Chest pain or pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Blacked-out/loss of consciousness	☐	☐	☐
Swelling of feet	☐	☐	☐
Swelling of the abdomen	☐	☐	☐
Palpitations	☐	☐	☐
Do you exercise?	☐	☐	☐
Special diet	☐	☐	☐
Valve disease/valve replacement	☐	☐	☐
Diabetes	☐	☐	☐
Rheumatic fever	☐	☐	☐
Gastrointestinal			
Heartburn	☐	☐	☐
Indigestion	☐	☐	☐
Nausea	☐	☐	☐
Abdominal pain	☐	☐	☐
Ulcers	☐	☐	☐
Hepatitis	☐	☐	☐
Blood in the stool	☐	☐	☐
Dark, tarry/ black stools	☐	☐	☐
Blood transfusion	☐	☐	☐

	Now	Never	Past
Hematologic/Lymphatic/Cancer			
Enlarged glands (lymph nodes)	☐	☐	☐
Excessive bruising	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Constitutional/General			
10lbs gain or loss in the last year	☐	☐	☐
Fever in the past month	☐	☐	☐
Chills or sweating	☐	☐	☐
Neurological			
Frequent headaches	☐	☐	☐
Dizziness	☐	☐	☐
Seizures or slurred speech	☐	☐	☐
Psychiatric			
Anxiety	☐	☐	☐
Memory loss	☐	☐	☐
Depression	☐	☐	☐
Mental illness	☐	☐	☐
Eyes/Ears/Nose/Mouth/Throat			
Blurred or double vision	☐	☐	☐
Cataracts or glaucoma	☐	☐	☐
Hearing loss	☐	☐	☐
Sore throat/hoarseness	☐	☐	☐
Sinus problems	☐	☐	☐
Nosebleeds	☐	☐	☐
Respiratory			
Wheezing or asthma	☐	☐	☐
Persistent cough	☐	☐	☐

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Review of Systems: Please indicate any personal history below:

	Now	Never	Past
Musculoskeletal			
Joint pain/stiffness/swelling	☐	☐	☐
Back aches	☐	☐	☐
Muscle weakness	☐	☐	☐
Osteoporosis	☐	☐	☐
Genitourinary			
Frequency of urination	☐	☐	☐
Burning pain when urinating	☐	☐	☐
Bloody urine	☐	☐	☐
Urinary tract infections	☐	☐	☐
Stones or kidney problems	☐	☐	☐
Skin			
Rashes	☐	☐	☐
Endocrine			
Excessive thirst/urination	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid disease	☐	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform any necessary services I may need.

Patient or guardian signature _____ Date _____

Doctor's signature _____ Date _____

NAME _____ DATE OF BIRTH_____

HEALTH MAINTENANCE

Please document the date of last completion and results if appropriate for the following:

Screening	Date Completed	Result/Comments
Pap smear / pelvic (women only)	_____	Normal or Abnormal?
Mammogram	_____	Normal or Abnormal?
Colonoscopy	_____	Normal or Abnormal?
Colorectal Screening	_____	Normal or Abnormal?
DEXA/Bone Density Scan	_____	Normal or Abnormal?
PSA (men only)	_____	Normal or Abnormal?

Any Recent Falls? ☐ Yes/ No ☐ Details: _____

Hospitalized for Falls? ☐ Yes/ No ☐ Details: _____

Social Needs Assessment (SDOH) Section

Housing Stability: Check One
"What is your housing situation today?"
( ) I have a steady place ( ) I do not have a steady place ( ) I am worried I might lose my housing

Food Security: Circle One
"Within the past 12 months, did you worry that your food would run out before you got money to buy more?" (Often true / Sometimes true / Never true)

Transportation: Circle one
"Has lack of transportation kept you from medical appointments, meetings, work, or getting things needed for daily life?" (Yes / No)

Financial Strain / Utilities: Circle one
"In the past 12 months, has it been hard to pay for basics like food, housing, or heating?" (Yes / No)

Safety & Support: Circle one
"Do you feel physically and emotionally safe where you currently live?" (Yes / No)
"Do you have someone you can count on for help in times of need?" (Yes / No)

Access to Care: Circle one
“Have you been able to get medical or health care when needed?” (Yes/No)

Health Literacy: Circle one
“Do you need help reading or understanding your medical information?” (Yes/No)