



PATIENT MEDICAL HISTORY

Lifestest Medical Record # _____

Last Name _____ First _____ MI _____ Exam Date ____/____/____

Date of Birth ____/____/____ Age _____ Height _____ Weight (Lbs) _____: Male Female

SSN# _____ Referring Physician _____
(Used only for internal identification purposes. Is not given out or displayed)

If female is there any chance you could be pregnant? _____ Date of last menstrual cycle _____

Have you been seen in this office before? Yes No If yes when? _____

Do you have, or have you ever been told you have High Cholesterol? YES NO
HDL _____ LDL _____ Triglycerides _____ Total Cholesterol _____

Do you smoke? YES NO Packs per day _____ Years _____
Are you a FORMER SMOKER? YES NO Year quit _____ #Years smoked _____

Are you currently being treated for High Blood Pressure? YES NO Latest BP ____/____

Are you Diabetic? YES NO If yes: INSULIN ORAL MEDICATIONS

Have you ever experienced the following symptoms? N/A
 Chest Pain/Tightness/Pressure Shortness of Breath Abnormal Echo Known Heart Disease

Do you have a family history of?
 Stroke High Blood Pressure Diabetes Heart Attack Before age 55 Cancer _____

Have you had any of the following?
Heart Bypass Surgery YES NO Year _____
PTCA (Balloon Surgery) YES NO Year _____
Angiogram YES NO Year _____
Prior EBT Scan YES NO Year _____ Score _____
Stent Placement YES NO Year _____ What Artery _____

Have you ever had cancer? YES NO
If YES, please indicate type _____ Chemo Radiation Surgery

List any surgeries you have had _____

Table with 3 columns: Treatment, Medications, Dosage. Rows include Allergy, High Blood Pressure, Aspirin, Cholesterol Lowering, Diabetes, Gastro-intestinal/ Antacids, Hormone Replacement / Birth Control, Depression/Mood Altering, Vitamin Therapy, Other.