



Naugatuck Valley Cardiovascular Associates, LLC

Michael C. Malinics, D.O., F.A.C.C.

1625 Straits Turnpike, Suite 209, Middlebury, CT 06762

George V. Antonopoulos, M.D.

866-621-6822

203-758-9400 (fax)

Other Locations:

22 Old Waterbury Rd.
Southbury, CT 06488

205 So. Main St.
Thomaston, CT 06767

503 Wolcott Rd.
Wolcott, CT 06705

PATIENT MEDICAL HISTORY

Section A: Patient Demographics

Patient Name: _____ Today's Date: _____

Address: _____

City/State/Zip _____

Patient DOB: _____ Gender: M F Marital Status: M S W D

Occupation: _____ How long at this type of work: _____

Name of Primary Care Physician: _____

Who referred you to our office? _____

Emergency Contact: _____ Phone # _____

Section B: Medical Information

Do you have an Advanced Directive (e.g., Do Not Resuscitate Order) NO YES Specify: _____

Are you on a special or restricted diet? NO YES Specify: _____

Are you diabetic? NO YES Specify type of diabetes: _____

Females Only: Are you currently pregnant or trying to get pregnant? NO Yes Due date: _____

What special equipment or devices do you use at home? _____

Do you have home care services or agency services? _____

Section C: Tobacco/Substance Use

Do you smoke? NO YES If yes type of tobacco used: Cigarettes Pipe Cigars Chewing Tobacco

If yes, how long have you smoked? _____ Amount daily _____

Have you ever smoked in the past? NO YES For how long did you smoke? _____ # of years Quit _____

Do you drink alcohol? NO YES If yes, how often? _____ How many drinks daily? _____

Patient Name: _____

Section D: Medications

Please list ALL of the medications you currently take. Please include non-prescription medications (over the counter), vitamins and any herbal medicines.

Name of Medication	Dose	How often taken in a day?

Do you use any drugs or medications not listed above? _____

Are you allergic to any medications? NO YES Specify: _____

Are you allergic to any foods? NO YES Specify: _____

Are you allergic to latex? NO YES Specify: _____

Are you allergic to dyes used for Xrays? NO YES Specify: _____

Are you allergic to iodine or seafood? NO YES Specify: _____

Section E: Exercise Tolerance

Describe your regular exercise tolerance:

- Regular Exercise no limitations
- Active (over 2 flights of steps or comparable, with ease)
- Moderate (1-2 flights of steps or comparable, with ease)
- Limited (less than 1 flight of steps)
- Able to walk with assistance (cane, walker)
- Unable to walk, wheelchair bound or bedridden

Comments: _____

Section F: Medical History of Heart Disease

High Blood Pressure Medication? _____

Chest Pain With Activity At rest Comments: _____

Chest Pain combined with: Difficulty Breathing Sweatiness Nauseated feeling

Comments: _____

Numbness and or tingling – if so, where? _____

Heart Attack Date: _____ Name of Hospital where treated: _____

Heart Surgery Date: _____ Name of Hospital where treated: _____

Patient Name: _____

(Section F – Medical History of Heart Disease continued)

Angioplasty/Stent Date: _____ Name of Hospital where treated: _____

Heart Rhythm problem or palpitations Describe: _____

Pacemaker or Internal Cardiac Defibrillator Type: _____ Date last checked: _____

Who monitors your pacemaker checks? _____

Heart valve problem or congenital abnormality Describe: _____

Are you currently being treated for this? _____

Congestive Heart Failure or fluid in your lungs Describe: _____

Are you currently being treated for this? _____

History of heart attack or cardiac disease in immediate family members (parents, siblings)? _____

Section G: Special Cardiac Testing

Cardiac Stress Test Date: _____ Location: _____

Nuclear Cardiac Stress Test Date: _____ Location: _____

Echocardiogram Date: _____ Location: _____

Cardiac Catheterization Date: _____ Location: _____

Other _____ Date: _____ Location: _____

Section H: Lung Disease

Asthma/Wheezing Emphysema COPD Sleep Apnea Tuberculosis Other _____

Section I: Other Medical Conditions

Kidney Disease Dialysis Kidney Transplant Kidney Surgery (specify) _____

Bladder/Urinary disorder(s) including infections (specify) _____

Adrenal Disease Specify: _____

Stomach ulcers Hiatal hernia (repair? _____) Unable to lie flat without heartburn

Fainting spells and/or syncope episodes

Diabetes How is it controlled? Insulin Pills Diet Comments: _____

Thyroid Are you on Thyroid medication? _____

Neurologic Disease Parkinson's Disease Seizures Stroke – Date: _____

Are you on any medications for the above conditions? _____

Patient Name: _____

(Section I: Other Medical Conditions continued)

- Sickle Cell Leukemia
- Excessive Bleeding Currently taking or history of taking blood thinning medications (Coumadin, Lovenox)
- Taking aspirin or aspirin containing medications
- Blood Clots (legs or Lungs) – Specify _____
- Arthritis Osteoporosis
- Liver Disease Hepatitis - When? _____ Other Liver Disease _____
- Hepatitis Specify type and treatment: _____
- HIV + Date: _____ Any treatment? _____
- Any other illness – Specify: _____

Patient Signature

Date

Person completing this form, if other than patient: _____

Relationship: _____

Signature: _____ Date: _____