CARY CARDIOLOGY, P.A.

LOCATIONS:

Cary Office:
300 Keisler Drive, Suite 204, Cary, NC 27518-7014
Tel: 919-233-0059 Fax: 919-233-0343

Fuquay-Varina Office:
400 Attain St, Fuquay-Varina, NC 27526
Tel: 919-586-7699 Fax: 919-586-7695

Dunn Office:
145 Tilghman Drive, Suite 100, Dunn, NC 28334
Tel: 910-891-7007 Fax: 910-891-7010

Benson Office:
1 Medical Drive, Benson, NC 27504
Tel: 919-233-0059 Fax: 919-233-0343
Appointments scheduled by our Cary Office.

Welcome to Cary Cardiology!

Name_____

Has an Appointment with_____

At our _____ office

Mon Tue Wed Thurs Fri

Date _____ Arrival Time_____ AM PM

Appt. Time _____ AM PM

If you are unable to keep your appointment, please give our office 24 hours' notice. Call 919-233-0059

We thank you for choosing our practice to assist you in your healthcare needs. In order to provide you with the best experience possible, please note the following information before your visit:

- ☐ Bring your current insurance cards
- ☐ Bring your current photo I.D.
- ☐ Please complete and bring the front and back of the patient history form
- ☐ Please complete and bring the enclosed consent for treatment and consent for information release forms
- ☐ Please bring all medications that you are currently taking
- ☐ Remember to bring any applicable co-pay for your visit

We realize you have a choice in who provides your cardiac care, and thank you for choosing Cary Cardiology!

Office Place Sticker Here

CARY CARDIOLOGY, P.A.

MEDICAL HISTORY FORM (PLEASE COMPLETE ALL 3 PAGES OF THIS FORM)

Patient Name: _____ Date of Birth: _____ Primary Doctor: _____

Pharmacy: _____ Reason for Visit: _____

Communications

Home Phone: _____ Acceptable to leave message: ☐ Yes ☐ No

Cell Phone: _____ Acceptable to leave message: ☐ Yes ☐ No

Drug Allergies/Reaction/Date

You may list additional allergy information on the back of this form.

1. _____ **2.** _____ **3.** _____

Medications

Please list dosage and times per day. Use back of paper if you need to list additional medications.

1. _____ **3.** _____ **5.** _____

2. _____ **4.** _____ **6.** _____

Past Medical History

Please circle the following conditions if they apply to your medical history.

Abnormal EKG	Congestive Heart Failure	Diabetes mellitus	Kidney Disease
Aneurysm	Clotting/Bleeding Disorder	Heart Murmur	Myocardial Infarction
Arrhythmia	Congenital Heart Disease	Heart Valve Problem	Pulmonary Embolism
Asthma	COPD	Hyperlipidemia	Sleep Apnea
Atrial Fibrillation	Coronary Heart Disease	Hypertension	
Cancer	Deep Vein Thrombosis	Mitral Valve Prolapse	
Other:	_____	**Other:**	_____

Past Surgical History

Please circle the following surgeries if they apply to your history.

Ablation Procedure	CABG	Carotid Stent Placement	Pacemaker Insertion
Aneurysm Repair	Cardiac Catheterization	Coronary Angioplasty	Valve Replacement
Arterial Bypass	Carotid Endarterectomy	Coronary Stent Placement	Vein Surgery
Other:	_____	**Other:**	_____

Family History:

	Alive/ Deceased	Age/Age At Death	Arrhythmia	Clotting Disorder	Cancer	Heart Attack	Heart Disease	Heart Failure	Hyper-lipidemia	Hyper-tension	Diabetes
Mother											
Father											
Sister											
Brother											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											

Adopted ☐ Yes ☐ No Family History Unknown ☐

Other Family History: _____

_____

_____

Tobacco Use

☐ Yes ☐ Never ☐ Quit Date _____

Packs per day _____ Years smoked _____

Alcohol Use

☐ No ☐ Social ☐ Frequently

Glasses of wine _____

Cans of beer _____

Drug Use

☐ Yes ☐ Never ☐ Quit

Type of Drug _____

Shots of Liquor _____

Smokeless Tobacco

☐ Yes ☐ Never

Flu Vaccination

Flu Shot ☐ Yes ☐ No Month & Year _____

Covid Vaccination

☐ Yes ☐ No Month &Year_____

Additional Drug Allergy Information

_____

_____

Additional Medications

_____

_____

_____

_____

_____

Review of Systems *(please check any of the following that you have experienced in the **last 3 weeks**.)*

Constitutional
- ☐ Changes in appetite
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Recent Weight Gain (_____ lbs)
- ☐ Recent Weight Loss (_____ lbs)

Skin/Integumentary
- ☐ Change in a wart or mole
- ☐ Rash
- ☐ Sores that won't heal

Eyes
- ☐ Difficulties with Vision
- ☐ Double Vision
- ☐ Eye Pain

Ear, Nose, Throat (ENT)
- ☐ Difficulties with Hearing
- ☐ Loss of Hearing
- ☐ Ringing in the ears
- ☐ Cold Symptoms
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Seasonal Allergies
- ☐ Snoring

Cardiovascular
- ☐ Fainting
- ☐ Irregular Heart Beat
- ☐ Swelling of Extremities
- ☐ Chest Pain
- ☐ Heart Rate is Fast
- ☐ Varicose Veins
- ☐ Calf Cramps
- ☐ Difficulty Breathing on Exertion

Gastrointestinal
- ☐ Black, tarry stool
- ☐ Bloody stools
- ☐ Constipation
- ☐ Indigestion
- ☐ Heartburn
- ☐ Vomiting

Genitourinary
- ☐ Blood in urine
- ☐ Urinating at night
- ☐ Painful urination
- ☐ Kidney Stones
- ☐ Painful intercourse

Women:
- ☐ Last menstrual period:_____
- ☐ Menstrual irregularities

Musculoskeletal
- ☐ Joint Pain
- ☐ Muscle Pain

Respiratory
- ☐ Wheezing
- ☐ Cough

Neurological
- ☐ Numbness
- ☐ Headaches

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Substance Abuse

Endocrine
- ☐ Cold Intolerance
- ☐ Excessive Urination
- ☐ Heat Intolerance

Heme/Lymph
- ☐ Easy bruising
- ☐ Enlarged Lymph Nodes
- ☐ Bleeding disorder

List all other symptoms you are experiencing that you need to discuss:

_____

_____

_____

_____

_____