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New York Cardiology Associates, P.C.

History and Physical Form

Name:		Date:
Address:		Best Phone Number:
DOB:	Age:	Email:
Do you give consent to communicate via email about non-urgent matters? ☐ Yes ☐ No		

Referred By:		Phone Number:
Other Physician(s):		

Reason for today's visit

Current Medications and Supplements

Name	Dosage	Frequency

Allergies
Please describe any allergies to MEDICINES, FOOD or OTHER products:

Vaccinations (Internal Medicine Patients Only)
Please include the date of any vaccinations

Tetanus:	Pneumococcal:	Shingles:
Influenza (current season only):	Other:	

(Continued on page 2)

Hospitalizations and/or Surgeries Please describe and include the date, hospital and reason:

Personal History			
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced			Children: ___ Sons ___ Daughters
Do you **currently** smoke? ☐ Yes ☐ No Have you **ever** smoked? ☐ Yes ☐ No	If you **currently** smoke: How many packs per day? ____ Year started? ____		If you have **ever** smoked: How many packs per day? ____ For how long? ____ When did you stop? ____
Do you drink alcohol? ☐ Yes ☐ No	How many per day? ___Wine ___ Beer ___Liquor	Do you drink caffeine? ☐ Yes ☐ No	How many per day? ___Coffee ___ Tea ___Soda
Occupation:		Do you exercise? Please describe:	

Past Medical History Please indicate if you have ever had any of the following:					
Hypertension		Stroke		Lung Disease	
High Cholesterol		Cancer		Liver Disease	
Heart Murmur		Fainting		Kidney Disease	
Angina		Vascular Disease		Rheumatoid Arthritis	
Heart Attack		Diabetes		Gastrointestinal	
Irregular Heart Rhythm		Thyroid Disease		Prostate (men only)	
If you indicated that you have any of the above medical problems, please elaborate:					

Family History				
		If Living	**If Deceased**	
	Sex	Age	Age at Death	Cause
Father				
Mother				
Brothers/Sisters				