Main Line HealthCare
Physician Network

Lankenau Heart Group

Patient Name:_____ **DOB:**_____

SOCIAL HISTORY

Marital Status: ☐ Married, Spouse's name_____
☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Other _____

Children: ☐ No ☐ Yes (ages) _____
Occupation:_____ Employer:_____

Diet: ☐ Regular ☐ Low fat, low cholesterol ☐ Low salt ☐ No added salt ☐ Diabetic
☐ Renal ☐ Weight loss ☐ Low carbohydrate ☐ Vegetarian

Do you smoke: ☐ No ☐ Yes ☐ Former
If yes, type of tobacco_____ Packs/day_____ How many years_____ Year quit_____

Alcohol: ☐ No ☐ Yes ☐ Former (year/quit)_____)
☐ Rarely ☐ Social ☐ Daily ☐ Frequently ☐ Occasional

Exercise: ☐ Sedentary ☐ Regular ☐ Occasional ☐ Active Lifestyle ☐ Weight lifting
☐ Aerobic ☐ Physically unable

Advanced Directives: ☐ None ☐ Living Will ☐ Proxy

Family History: please indicate any illness(es) including their age at time of onset or death:

☐ Adopted, Family history unknown	Mother Age____ Deceased_____	Age of Onset	Father Age_____ Deceased_____	Age of Onset	Siblings Age_____ Deceased_____	Age of Onset
Heart Attack						
Angioplasty/Stent						
Bypass Surgery						
Stroke						
Hypertension						
Diabetes						
High Cholesterol						
Congestive Heart Failure						
Congenital Heart Disease						

Review of Systems: Indicate if you have had any of the following (within past 6 months):

☐ Chest discomfort (pain, heaviness, burning, tightness)
☐ Swelling of ☐ hands ☐ feet ☐ legs
☐ Weight gain/amount_____lbs.
☐ Anemia (low hemoglobin)
☐ Weight loss/amount_____lbs.
☐ Hematuria (blood in urine)
☐ Dyspnea (shortness of breath)
☐ Vision changes
☐ Palpitations
☐ Fever
☐ Snoring
☐ Nausea
☐ Nocturia (frequent urination at night)
☐ Orthopnea (shortness of breath while lying flat)
☐ Depression
☐ Tremors
☐ Hemoptysis (spitting up bloody mucus)
☐ Reflux
☐ Bleeding
☐ Fatigue
☐ Joint pain
☐ Myalgias (muscle pain)
☐ Memory loss
☐ Erectile Dysfunction
☐ Hearing loss
☐ Goiter
☐ Skin sores
☐ Rash
☐ Hallucination
☐ Dizziness
☐ Weakness
☐ Seizures