



New Patient Worksheet

Thank you for choosing the **Atallah Heart Center** for your medical care. Please complete bring it to your appointment. You can also mail it to us:

ATTN: Medical Records
Mail: PO Box 82177, Rochester, Michigan 48308

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth _____ Last 4 SSN _____

Home Address _____

Home Phone: _____ Cell phone: _____

Email _____

Emergency Contact Name & Relation: _____

Emergency Contact Phone Number: _____

Would you like access to our **Patient Portal** to access your medical records? Y/N

Who is your current Primary Care Doctor _____

******Please have all of your previous medical records faxed to the Atallah Heart Center prior to your visit if you are being seen for cardiology. Fax 248-413-5170.***

Please list all other physicians you see: (Please include their name and specialty and the condition they are treating).



Reason for visit: What health issues do you want to focus on at your visit?

What are your current medical conditions? (Heart disease, high blood pressure, high cholesterol, diabetes, etc.)

Medical History: Please list any major past illnesses, hospitalizations (include year or date if known).

Surgeries: List any past surgeries (and what year/date).



Family History: Have your close relatives, parents, siblings, children, or grandparents had any of the following?

Heart attack, Angina/Chest pain, Congestive Heart Failure, Coronary Artery Bypass Surgery, Stroke, High blood pressure, Blood clots (DVT, or Pulmonary Embolism), High Cholesterol, Diabetes, Thyroid disease, Breast cancer, Other Cancer--what type?, Kidney Disease, Lupus, Rheumatoid Arthritis, Asthma, Mental Health disorder, Substance Abuse.

If yes, which relative? And at what age were they diagnosed?

Do you have Medication allergies? Yes No

If yes, please list the medication(s) and your reaction.

Please list all prescribed and over-the-counter medications you take regularly. Please include all supplements, vitamins or herbal products. List the dose and when you take them:



Do you use alcohol, caffeine, energy drinks, tobacco, or any recreational drugs? If so how often? If you have a history of smoking, how many packs per day and for how many years did you smoke?

Please complete the chart below.

Health Maintenance	Date:
Flu Vaccine	
Pneumonia Vaccine	
TDAP	
Shingles Vaccine	
EKG	
Colonoscopy	
Mammogram (Female)	
Prostate Specific Antigen (Male)	
Pap/Pelvic Exam (Female)	
Bone Density	
Pulmonary Function Testing	
Stress Test	
Blood work	
Diabetic Eye Exam (Diabetic)	
Diabetic Foot Exam (Diabetic)	
Hemoglobin A1C (Diabetic)	
Date of Last Complete Physical	



Personal and Professional Development: What is your current or past occupation:

Employed Unemployed Disabled Retired Care-taking Other

Have you had hazardous environmental or occupational exposures (chemicals, dust, mold, paints, radiation)? If yes, please describe:

Review of Symptoms: Are there any other medical issues you would like to address?

Is there anything else that would be helpful for us to know about you?
