Seth J Baum, MD, FACC, FACPM, FAHA, FNLA, FASPC

7900 Glades Road, Suite 400 Boca Raton, FL 33434
Phone 561.488.5535 -- Fax 561.488.2150
www.preventivecardiologyinc.com
Email: Lipids@preventivecardiologyinc.com

WELCOME TO OUR OFFICE

What is your name? _____ How old are you? _____

Date of Birth? _____ Married/Single? _____ Male/Female? _____

Hispanic/Non-Hispanic_____ # of children_____ # of grandchildren_____

Address_____

_____ SS# _____

Home Phone_____ Cell_____ Email_____

Emergency Contact Name/Number_____

How did you hear about us? _____

Who is your primary doctor? _____

Primary Insurance carrier*_____ ID Number_____

***We do not accept any insurance; payment is due in full at the time of service. If you have provided your insurance information we will be happy to submit a claim for you.**

Dear Patient:

In order to assist us in obtaining an accurate history of your medical condition, please answer the following questions:

What medications or nutritional supplements are you allergic to or do you have intolerance to? _____

_____

Cardiovascular Risk Factors: Please check all that apply and describe:

- Cigarette smoking (if yes, how many packs per day, for how long, and when did you quit) _____

- Hypertension (BP >140/90 mm Hg or on antihypertensive medication)

_____

- Low HDL cholesterol (< 40 mg/dl for men or <50 mg/dl for women)
- Family history of premature Coronary Heart Disease (CHD) that includes:
  CHD in male first-degree relative <55 years of age
  CHD in female first-degree relative <65 years of age
- Age (Men > 45 years, Women > 55 years)
- Autoimmune disorder (such as Rheumatoid Arthritis or Lupus)

_____

- Pregnancy History of:
  - Hypertension
  - Diabetes
  - Spontaneous preterm delivery
  - Pre-Eclampsia or Eclampsia
  - Small for gestational age baby

Cardiovascular Risk Equivalents, Including: Please check all that apply:

- Peripheral arterial disease
- Abdominal aortic aneurysm
- Transient ischemic attacks or stroke of carotid origin
- ≥50% obstruction of a carotid artery
- Diabetes Mellitus

Do you have a history of any cholesterol abnormality? This includes a high LDL, a low HDL, or a high triglyceride level.

_____

Please describe your exercise regimen including the frequency, duration, type, and intensity of exercise.

_____

_____

_____

Please describe your typical diet in detail. Include snacks, desserts, soft drinks, and the quantity of water you drink.

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Water_____

Soft drinks_____

How much alcohol do you drink? Please describe the type of beverage, frequency of beverage, and number of drinks per week.

_____

Past Medical History: Have you ever had? Please check all that apply.

- Stroke
- Mini stroke (TIA)
- Claudication
- Heart attack
- Stent or angioplasty
- Bypass surgery
- An aneurysm
- Cardiomyopathy
- Valvular heart disease
- Shortness of breath with exertion
- Shortness of breath at rest
- Shortness of breath that awakens you from sleep
- A fainting spell
- A heart rhythm disturbance
- Palpitations
- An ablation
- Ulcer disease
- Diverticulitis
- Hiatal hernia
- GERD
- Irritable bowel syndrome
- Liver problems
- Hepatitis
- Any other gastrointestinal problem
- Osteoporosis
- Osteopenia
- Thyroid disease
- Low testosterone
- Low vitamin D
- Hormone replacement therapy
- Skin disorders
- Skin cancer
- Cancer (please describe)
- A blood disorder
- Asthma
- Pneumonia
- Bronchitis
- COPD
- A CT scan with contrast (dye)
- An MRI
- An echocardiogram
- A carotid ultrasound
- A Holter monitor
- A stress test
- A cardiac catheterization
- An angioplasty or stent

Past Surgical History:

Please list any surgical procedures you have had with the date and location.

_____
_____
_____
_____
_____

Medications and Nutritional Supplements:

Please list all medications and nutritional supplements including their doses.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

RECORDS RELEASE AUTHORITY

To:

_____

_____

_____

(Please print Doctors Name and address and # in the space provided above)

I, _____, hereby request that you release a report of my evaluation, diagnosis, and treatment including blood work and other pertinent test results

To:

Seth J Baum, MD, FACC, FACPM, FAHA, FNLA, FASPC

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Patient Name (printed)_____Date of Birth_____

Signature_____Date of Request_____