



CRS

Cardiac Rhythm Specialists, Inc.

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*Diplomate American Board of Cardiovascular Disease
Cardiac Electrophysiology*

Chart #: _____

Physician's Signature

Date

NEW PATIENT MEDICAL HISTORY

Patient's Name _____ Date _____

Address _____

Phone Number _____

Date of Birth _____ Age _____ Marital Status _____

Referring Physician and Address _____

Other physicians you would like to receive a report or letter _____

Reason for referral or visit _____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.

	Medication	Dosage	How often per day	How long have you been taking this?
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

ALLERGIES

LIST ALL DRUG ALLERGIES & YOUR REACTION TO THE MEDICATIONS.

MEDICAL HISTORY

LIST ALL HOSPITALIZATIONS, STARTING WITH THE MOST RECENT AND PROGRESSING BACKWARDS. INCLUDE ALL HOSPITAL ADMISSIONS, SURGERIES, & PREGNANCIES.

Illness	Date	Procedure	Where

1. Have you ever had cardiac catheterization? Yes No
If yes, When _____ Where _____
2. Have you ever had a blood transfusion?
If yes, When _____ Where _____
3. Have you ever had ulcers or other gastrointestinal bleeding?
If yes, describe _____
4. Do you currently smoke cigarettes? Yes No
How many packs per day? _____ On average? _____ At most? _____
Do you have any serious intention to quit? Yes No
Have you quit smoking? Yes No
If yes, when? _____
How many years did you smoke? _____
Does your spouse smoke? Yes No
5. Do you drink alcohol? Yes No If yes, how much: _____
6. Do you drink beverages containing caffeine? Yes No If yes, how much a day? _____
7. Do you use any recreational drugs? Yes No Describe: _____
8. FOR FEMALES:
If you have been pregnant, how many times? (include all) _____ # of live births _____
Menopause date of onset _____

FAMILY HISTORY

	If Alive, Age	If Alive, State of Health	If Deceased, Cause of Death	Age at Death
Mother				
Father				
Brothers				
Sisters				

SOCIAL HISTORY

1. Are you Employed Retired Your Occupation _____
2. Who lives at home with you? _____
3. Are you married? Yes No
4. Do you have any hobbies? Explain. _____
5. How many children do you have? _____