SAMIR JAIN MD, FACC
599 Route 37 West, Suite 5, Toms River, NJ 08755
Phone: 732-608-9737 Fax: 732-608-9744
Email: contact@samirjainmd.com www.samirjainmd.com

Medical History Form

Name: _____ Date of Birth: _____

Allergies: _____ Referred by: _____

Current Symptoms: _____

Please List Current Medications on back or attach a list

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Chest discomfort with exercise	yes no	Palpitations or heart fluttering	yes no
Chest discomfort at rest	yes no	Ankle or leg swelling	yes no
Night sweats	yes no	Unusual fatigue	yes no
Shortness of breath	yes no		

PERSONAL HISTORY:

High Blood Pressure	yes no	Arrhythmia/Atrial Fibrillation	yes no
Diabetes	yes no	Kidney Disease	yes no
High Cholesterol	yes no	Stroke	yes no
Smoking	yes no	Sleep Apnea	yes no
Heart Attack/ Angina	yes no	Carotid Disease	yes no
Previous Stress Test/Angioplasty	yes no	Peripheral Arterial/Venous Disease	yes no
Congestive Heart Failure	yes no	Other: _____	
Other: _____			

FAMILY HISTORY: (check off if any members listed below had the following diagnoses)

	MOTHER	FATHER	SIBLINGS
Heart Attack	_____	_____	_____
Heart Disease (specify)	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Stroke	_____	_____	_____
Heart Surgery	_____	_____	_____
Diabetes	_____	_____	_____
Cancer (specify)	_____	_____	_____
Other (specify)	_____	_____	_____

MAJOR SURGERIES/PROCEDURES: (what you can remember)

Date	Reason	Name of Hospital

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSTIC TESTS:

	DATE	PLACE OF SERVICE
Stress Test		
Echo Cardiogram (ultrasound)		
Cardiac Catheterization		
Heart Surgery		
Pacemaker/Defibrillator		