TUSCAN CARDIOVASCULAR CENTER
J. DOUGLAS OVERBECK, MD
701 TUSCAN DRIVE, SUITE #205
IRVING, TEXAS 75039
PHONE 972-253-2505 ♦ FAX 972-253-2506

NEW PATIENT FORM

Patient Name:____________________________ Pharmacy:__________________________________

Family Physician: ________________________ Previous Cardiologist: ______________________

PAST MEDICAL HISTORY

❒ Yes ❒ No Heart Disease
❒ Yes ❒ No Diabetes
❒ Yes ❒ No High Cholesterol
❒ Yes ❒ No Hypertension (high blood pressure)
❒ Yes ❒ No Lung Disease
❒ Yes ❒ No Pacemaker/Defibrillator
❒ Yes ❒ No Gastrointestinal
❒ Yes ❒ No Kidney Disease
❒ Yes ❒ No Stroke, TIA
❒ Yes ❒ No Bleeding Disorder
❒ Yes ❒ No Liver Disease
❒ Yes ❒ No Heart Attack

Other (please specify): ____

PAST SURGERIES (including Cardiac Stents, CABG)

____

____

PRESENT MEDICATIONS (including dosage & frequency) Do you take Aspirin daily?

____

____

____

MEDICATION ALLERGIES (including iodine, IV dye, & shellfish)

____

____

FAMILY HISTORY OF CARDIAC DISEASE (please specify)

____

____

Would you like to participate in our Follow Your Health program to view your clinical summaries, recent labs, vitals and medication lists? ______________________________

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NEW PATIENT QUESTIONNAIRE

MARITAL STATUS

❐ Single
❐ Married
❐ Divorced
❐ Separated
❐ Widowed

EXERCISE

❐ None
❐ Walk
❐ Run
❐ Aerobic
❐ Other: ______________________________

ALCOHOL USE

❐ Never
❐ Current, ____________ Months/Years
❐ Stopped, ____________ Date
❐ Social Drinker
❐ Moderate Drinker

TOBACCO USE

❐ Never
❐ Current
______________________ Months/Years
______________________ Packs per Day
❐ Stopped, ____________ Date
❐ Social Smoker
❐ Chewing Tobacco
❐ Nicotine Dependent
________ Wish to Stop
________ Attempted to Stop