JOHNSTOWN HEART & VASCULAR CENTER

Patient History

Patient Name: ______________________________ Date: ____________

Have you ever had?	No	Yes		No	Yes	Are you experiencing?	No	Yes
Hypertension			Hepatitis			Chills		
Chest pain			Diabetes			Fever		
Heart Attack			Anemia			Shortness of Breath		
Irregular Heartbeat			Gout			Chest Pain		
Pacemaker			Thyroid Disease			Numbness		
Cardiac Defibrillator			Phlebitis			Extremity weakness		
Asthma			Stroke			Resting pain		
COPD/Emphysema			Cancer			Pain when walking		
Sleep Apnea			High cholesterol			Temporary blindness		
Kidney Disease						Slurred speech		

Johnstown Heart & Vascular Center, is now in the process of transferring our paper charts to Electronic Medical Records (EMR). In order to comply with "meaningful use", we are asking our patients to fill out the following questionnaire.

Race: Check One

	American Indian		Alaskan Native		Asian
	African American		White		Native Hawaiian/Pacific Islander
	Decline to report/Unreported				

Ethnicity: Check one

	Hispanic/Latino		Non Hispanic/Latino		Decline to report/Unreported

Nationality______________________ **Decline to Report**______________________

Primary Language______________________ **Decline to Report**______________________

Social History	Current	Past	How Much?
Alcohol			
Illegal Drug Use			

Please Check Correct Box

Tobacco	Every day Smoker_____	Some day Smoker______	Former Smoker_____	Never Smoked_____

Patient Signature: ______________________________ Date: ____________