Name:________________________________ DOB__________DATE:__________

Dr Yoon’s New Patient Intake Form

Please check the boxes for the medical conditions you have or are being treated for:

Past Medical History

- High Blood pressure ☐
- High Cholesterol ☐
- Diabetes ☐
- Prior heart attack ☐
- Congestive heart failure ☐
- Aortic aneurysm ☐
- Stroke/TIA ☐
- Atrial Fibrillation ☐
- Cancer ☐
  - If yes what kind __________
  - ________________________________
- Bleed disorder ☐
- Clotting disorder ☐
- Peripheral vascular disease ☐
- Anxiety ☐
- Depression ☐
- Bipolar disorder ☐
- Sleep apnea ☐
- Acid reflux ☐
- Anemia ☐
- Gastrointestinal Bleed ☐
- Thyroid disease ☐
- Kidney disease ☐
- Liver disease ☐

Social History

- Smoking/Tobacco products ☐
  - If yes how much____________
- Alcohol ☐
  - If yes, how much___________
- Any Illegal drugs ☐
  - If yes, what________________
- Daily Exercise ☐
  - If yes what_________________

Past Surgical History

- Heart stents ☐
  - If yes when ______________
  - If yes where______________
- Leg stents ☐
- Heart Bypass ☐
- Vascular bypass ☐
- Carotid surgery ☐
- Hernia repair ☐
- Appendix ☐
- Tonsills ☐
- Hysterectomy ☐
- C-section ☐
- Amputations ☐
  - If yes, what? _____________
- Gall Bladder ☐

Family History

(close relatives)

- Heart attack ☐
  - If yes who______________
- Stroke ☐
  - If yes who______________
- Diabetes ☐
  - If yes who______________
- High Blood pressure ☐
  - If yes who______________
- Heart bypass ☐
  - If yes who______________
- Sudden Cardiac Death ☐
  - If yes who______________
- High Cholesterol ☐
  - If yes who______________

List Medication allergies:

____

____