

Cardiology of Virginia, Inc.

13572 Waterford Place, Midlothian, VA 23112

(804) 560-8782 (phone)

(804) 525-2525 (fax)

Patient History & Information

Date:		Name:				Date of Birth:					
Email address:											
Race	<input type="checkbox"/>	American Indian	<input type="checkbox"/>	Alaska Native	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Hawaiian or Pacific Islander			
	<input type="checkbox"/>	African American	<input type="checkbox"/>	White	<input type="checkbox"/>	Hispanic	<input type="checkbox"/>	Other:			
	<input type="checkbox"/>	I decline to answer									
Preferred Language		<input type="checkbox"/>	English	<input type="checkbox"/>	Spanish	<input type="checkbox"/>		Other:			
How should we contact you?		<input type="checkbox"/>	Home Phone	<input type="checkbox"/>	Cell Phone	<input type="checkbox"/>	Work Phone	<input type="checkbox"/>	Email	<input type="checkbox"/>	Mail
May we leave a message?		<input type="checkbox"/>	Home Phone	<input type="checkbox"/>	Cell Phone	<input type="checkbox"/>	Work Phone				

**Do you have or have you ever been treated for any of the following conditions?
(Please circle Y for Yes or N for No)**

Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, and Throat	<input type="checkbox"/>	<input type="checkbox"/>	Kidney-Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	HIV-AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy/Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	GI (stomach, bowel, liver)	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Others:		

Are you currently under the care of a Skilled Nursing Facility?		<input type="checkbox"/>	<input type="checkbox"/>
Name & address of Facility:			

Thank you for your responses to these questions. Please return the completed form to the front desk.