



MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD.

PATIENT MEDICAL INFORMATION

Name _____

Married ___ Single ___ Separated/Divorced ___ Occupation _____

HOSPITALIZATIONS

If you have ever been hospitalized, please list the approximate date and reason (i.e. surgeries)

| | <u>Date</u> | <u>Reason</u> |
|----|-------------|---------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

MEDICATIONS

Please list all medications you are currently taking.

| | <u>Name of Medicine</u> | <u>Dosage</u> | <u>When Taken</u> | <u>Prescribing Physician</u> |
|----|-------------------------|---------------|-------------------|------------------------------|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ | _____ |
| 8. | _____ | _____ | _____ | _____ |

ALLERGIES

If you have a Living Will, please provide Mid-Atlantic Cardiothoracic Surgeons, Ltd. and your primary care physician with a copy for your medical records.