Cardiovascular Care Associates

Dr. Daniel Brancheau DO, FACC
Dr. Talha Idrees DO, FACC
Dr. Charlotte Ng MD, FACC

9450 S Saginaw St., Suite E
Grand Blanc, MI 48439
Phone: (810) 428-6227
Fax: (810) 771-7410
Email: Appointments@cca-mi.com

Patient Name: _____ Date of Birth: _____ Telephone: _____

Age:____ Sex:____Height:_____Weight:_____Referring Physician:_____

Previous Cardiologist(s):_____

May we request previous records: □ Yes □ No

Reason for visit:

_____

_____

Allergies to Medicine(s): _____

Allergies to Foods, Dye, Other: _____

Past Medical History:

□ Heart Attack
□ High Blood Pressure
□ Angina
□ Stroke
□ Diabetes Mellitus
□ High Cholesterol
□ Cardiac catheterization and/or previous cardiac stents

__/__/___Date of most recent cardiac catheterization and/or stent implantation

□ Pacemaker _____Yes _____No

__/__/___Date of Implant. Make or Model: _____

Past Major Surgery:

1. _____
2. _____
3. _____

Current Medications (please include name, dosage and how often you take each medication):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Cardiovascular Care Associates

Dr. Daniel Brancheau DO, FACC
Dr. Talha Idrees DO, FACC
Dr. Charlotte Ng MD, FACC

9450 S Saginaw St., Suite E
Grand Blanc, MI 48439
Phone: (810) 428-6227
Fax: (810) 771-7410
Email: Appointments@cca-mi.com

Patient Name: _____ Date of Birth: _____ Telephone: _____

Personal History (please describe a typical day):

Smoking: _____Yes _____No _____Duration _____Amount

Alcohol: _____Yes _____No _____Duration _____Amount

Non-prescription Drugs: _____Yes _____No _____Duration _____Amount

Exercise:_____Type of exercise_____Frequency_____Duration

Family History:

□ Heart Attack or Sudden Death before age 65 years old	Father	Mother	Brother	Sister
□ Stroke	Father	Mother	Brother	Sister
□ Diabetes Mellitus	Father	Mother	Brother	Sister
□ Hypertension	Father	Mother	Brother	Sister
□ High Cholesterol	Father	Mother	Brother	Sister

Have you had any falls in the past 6 months? □ NO □ YES. If yes, tell us what happened.

Work History

Do you currently work? □ YES □ NO

Job:_____ □ Retired □ Homemaker

Employer:_____ □ Unemployed

Location:_____ □ On disability

Please send the completed form via fax, email, or postal service prior to your appointment.