Atlantic Health Partners
Affiliated with
Atlantic Health System

Marc Mandel, M.D., F.A.C.S.

Abbreviated Medical History

Patient Name: ____ **DOB:** ____________________

Reason for visit____

____

Primary Care Physician____

Specialists (phone # if you have) ____

____

____

Which of your Doctors sent you? ____

Major/Chronic Medical Illnesses / What are your meds treating ?

____

____

____

Prior Surgeries____

____

____

Implants (e. g. pacemaker, joints) ____

Prescribed Medications Only ____

____

____

Blood Thinners
Aspirin_______________
Coumadin_____________
Plavix________________
Brilinta_______________
Eliquis_______________
Xarelto_______________
Other________________

Cardiac Stents__________________________________
Deep Vein Thrombosis/Pulmonary Emboli_______
____

Allergies/reaction____________________________
____
____

Smoking packs per day and number of years____
Smokeless tobacco? ____
Alcohol drinks per week____
Illicit drugs describe____
In recovery? ____

Family history of Cancer or Heart Disease (parents, siblings, children only)_______________
____

Patient Signature: ____ **Date:** ___________________