New Patient Medical Questionnaire

DATE: ____________

Patient Name: ________________________________ Date of Birth: __________ AGE: _____
Primary Care Physician: ____
Other Physicians: ____
What physician requested this consultation? ____
Pharmacy Name: ________________________ Location (nearest intersection): ____________

CHIEF COMPLAINT

What problem(s) are you here for today? ____

____

____

CORONARY RISK FACTORS: (please check if you have or have had any of the following and year it was first identified)

__ Hypertension (high blood pressure) ________
__ Diabetes (if yes, taking pills or insulin) _____
__ Abnormal/High Cholesterol _______________
__ Peripheral Artery Disease (carotid, legs)______
___Family History of heart disease _______
___ Obstructive Sleep Apnea ___________
___CPAP Machine ____________________
___Current smoker or___Former Smoker

CARDIOVASCULAR HISTORY

Please check any for all that apply, and year of first diagnosis.

___ Coronary Artery Disease__________
___ Heart Attack ___________________
___ Enlarged heart __________________
___ Heart Murmur___________________
___Stroke or TIA (mini-stroke) _________
___ Heart Valve disease _______________
___ Carotid Artery Disease/Stenosis ______________
___ Pulmonary Embolism (blood clot in lung) _____
___ Aneurysm _______________________________
___Pacemaker _______________________________
___Defibrillator _____________________________
___Arrhythmia (Abnormal Rhythm) _____________
___ Peripheral Arterial Disease (blockages in leg arteries)______________________________
___ Congestive heart failure (weak heart muscle) ___________________________________
___ Deep Vein Thrombosis (DVT, blood clot in leg) _________________________________
___ Hospitalization for any heart reason ____

CARDIAC PROCEDURES/DIAGNOSTIC TESTING

Check for all that apply and year of procedure.

___ Heart or Cardiac Catheterization

____

___ Heart/Leg or other Angioplasty/Stent Placement

____

___ Electrophysiology or Ablation Procedure

____

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CURRENT MEDICATIONS / SUPPLEMENTS

Please list ALL medications that you are taking at home. Include ALL prescription medications, non-prescription medications, vitamins, herbal remedies and supplements

Name of Medication/Dose/How often or when taken

Example: lasix 40 mg twice a day

1) ____________________ ____________ ____________________
2) ____________________ ____________ ____________________
3) ____________________ ____________ ____________________
4) ____________________ ____________ ____________________
5) ____________________ ____________ ____________________
6) ____________________ ____________ ____________________
7) ____________________ ____________ ____________________
8) ____________________ ____________ ____________________
9) ____________________ ____________ ____________________
10) ___________________ ____________ ____________________

(Please attach additional pages if necessary)

ALLERGIES / INTOLERANCES TO MEDICATIONS

Please list any medications, foods, or materials such as contrast dye or iodine that you are allergic to, had an adverse reaction to or do not tolerate and describe the reaction.

Medication Reaction (e.g. hives, swelling, shortness of breath, rash, etc.)

Example: lipitor -> hives, muscle aches

____
____
____
____

SURGICAL HISTORY / OPERATIONS

Please list any other surgeries you have had and include the year.

Surgery	**Date**
Example: Gallbladder Removed	*1988*

____
____
____
____
____

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PAST MEDICAL HISTORY

Check for all that apply and indicate the year it was first identified

PULMONARY:

___ Asthma_____________________________ ___ Pneumonia________________

___ Emphysema / COPD________________________

GASTROINTESTINAL:

___ Gastrointestinal Bleeding_________________ ___Ulcers_________________

___ Reflux (GERD)__________________________ ___Liver Disease / Hepatitis___

RENAL/GENITOURINARY

___ Kidney Disease / Elevated Creatinine________ ___ Prostate Disease____________

___ Dialysis________________________________

NEUROLOGICAL / PSYCHOLOGICAL:

___Intracranial (in the brain) Bleeding_____________ ___Seizure Disorder______________

___ Dementia_________________________________ ___ Depression__________

___ Anxiety Disorder__________________________ ___ Parkinson's ___________

FEMALE REPRODUCTIVE: Not Applicable

___ Menopause (at what age?)___________ ___Currently Pregnant (number of weeks)___

ENDOCRINE:

___ Thyroid Disorder___________________________

OTHER:

___ Cancer (type)___________________ ___ HIV_______________________

___ Clotting Disorder________________ ___ Autoimmune Disorders (i.e.Lupus)________

___ Bleeding Disorder________________ ___ Arthritis_______________________

___ Anemia___________________________________

SOCIAL HISTORY:

Marital Status (circle): Single Married Divorced Separated Widowed Domestic Partner

Number of children: ______________ With whom do you live?_________________________

Are you retired: Yes No Current or Previous Occupation: ______________________________

Leisure activities: (Include any hobbies)

____

Exercise (circle)

No/Sedentary Occasional Regular Active Lifestyle Physically unable to exercise

Type of exercise and how long (how many minutes and times per week): ___________________

____

____

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Do you use tobacco? Yes Formerly Never

Cigarettes/Cigars/Pipe/Chewing tobacco/Electronic cigarette (Circle which one)

________________ per day Years Smoked? ______________ Quit Date?_________________

Do you use alcohol? Yes Formerly Never

Beer/Wine/Spirits (Circle which one)

______ servings per day / wk / mo / yr

Do you use caffeine? Yes Formerly Never

Caffeinated Coffee/Tea/Soda? (Circle which one)

_____cups per day / wk / mo / yr

Do you use recreational drugs? Yes Formerly Never

Marijuana/Cocaine/Methamphetamine/Heroin/Other _______________________

Date quit?________Rehab?________

Currently on any particular diet? Which one?: _______________________________

FAMILY HISTORY:

Please indicate if your Father, Mother, Brother(s) or Sister(s) have or have had the following diagnoses and their age when it was diagnosed.

Heart Attack, Stroke, Angioplasty/Stents, Heart Surgery, Congestive Heart Failure, Blood Clots, Aneurysm, or Abnormal Heart Rhythm

	Current Age	Diagnosis (age of diagnosis)	Age of Death (if applicable and cause of death)
Father	_______	________________	______________________________________
Mother	_______	________________	______________________________________
Brother(s)	_______	________________	______________________________________
	_______	________________	______________________________________
Sister(s)	_______	________________	______________________________________
	_______	________________	______________________________________
Other	_______	________________	______________________________________
	_______	________________	______________________________________

Check here if Adopted/Unknown family history __

New Patient Medical Questionnaire

Patient
Name:____________________________________DOB:________________

REVIEW OF SYTEMS

Date: _____________

Please check if you have any of the following symptoms:

CONSTITUTION	**EYES**	**GASTROINTESTIONAL**	**ENDO/HEME/ALL**
Fever	Blurred Vision	Heartburn	Easy bruising
Chills	Double Vision	Nausea	Allergies
Weight loss	Sensitive to light	Vomiting	Excessive thirst
Fatigue	Eye Pain	Abdominal pain	**NEUROLOGICAL**
Sweating/Perspiration	Eye Discharge	Diarrhea	Dizziness
Weakness	Eye redness	Constipation	Tingling
SKIN	**CARDIOVASCULAR**	Blood in stool	Tremor
Rash	Chest Pain	Black stool	Sensory change
Itching	Palpitations/flutters	**GENITOURINARY**	Speech change
HENT	Shortness of breath	Painful urination	Focal weakness
	when lying down	Urgency	Seizures
Headaches	Leg pain while walking	Urinary frequency	Loss of consciousness
Hearing loss	Leg swelling	Blood in urine	**PSYCHIATRIC**
Ringing in the ears	Waking from sleep	Flank pain	Depression
Ear Pain	short of breath	**MUSCULOSKELETAL**	Suicidal ideas
Ear Discharge	**RESPIRATORY**	Muscle pain	Substance abuse
Nosebleeds	Cough	Neck pain	Hallucinations
Congestion	Coughing up blood	Back pain	Nervous/Anxious
Sore throat	Sputum production	Joint pain	Insomnia
	short of breath	Falls	Memory loss
	Wheezing		