

New Patient Medica	l Questionnaire	DATE:
Datiant Nama	Data of Pirth	ACE
Patient Name: Primary Care Physician:		AGE:
Other Physicians:		
What physician requested this consultation?		
Pharmacy Name:	_Location (nearest interse	ection):
CHIEF COMPLAINT		
What problem(s) are you here for today?		
CORONARY RISK FACTORS: (please ch	eck if you have or have l	had any of the following

# **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)	Family History of heart disease
Diabetes (if yes, taking pills or insulin)	Obstructive Sleep Apnea
Abnormal/High Cholesterol	CPAP Machine
Peripheral Artery Disease (carotid, legs)	<u>Current smoker or</u> Former Smoker

#### CARDIOVASCULAR HISTORY

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

Coronary Artery Disease	Carotid Artery Disease/Stenosis			
Heart Attack	Pulmonary Embolism (blood clot in lung)			
Enlarged heart	Aneurysm			
Heart Murmur	Pacemaker			
Stroke or TIA (mini-stroke)	Defibrillator			
Heart Valve disease	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

#### **New Patient Medical Questionnaire**

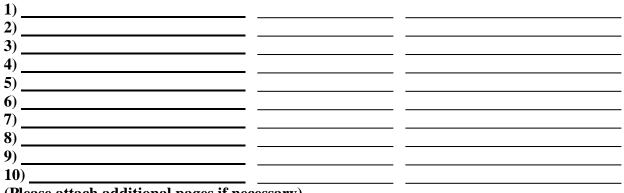
 New Patient Medical Questionnaire

 Patient Name:
 DOB:

#### **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* 



(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

	DOB:
PAST MEDICAL HISTORY	it may fingt identified
Check for all that apply and indicate the year PULMONARY:	it was first identified
	Droumonio
Asthma 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	
Dementia	
Anxiety Disorder	Parkinson's
	_
FEMALE REPRODUCTIVE: Not Applicabl Menopause (at what age?)	
Menopause (at what age?)	Currentry Pregnant (number of weeks)
ENDOCRINE:	
Thyroid Disorder	
OTHER:	
	HIV
Cancer (type)	HIV Autoimmune Disorders (i.e.Lupus)
	Autoimmune Disorders (i.e.Lupus)

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):

New Patient Medical Questionnaire
Patient Name:DOB:
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
<b>Do you use recreational drugs? Yes Formerly Never</b> 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		