

Comprehensive Cardiology of Stamford and Greenwich

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We ask that all patients fill out this form at the time of their first visit to the office. Please do your best to answer all of the questions. If you do not understand the questions, your doctor or nurse can explain them. These questions are meant to help us take care of you. Everything is CONFIDENTIAL and part of your medical record.

Name: _____ DOB: _____ Today's Date: _____

What brings you in today? _____

MD's Comments: _____

Do you have a Primary Care Physician or other doctors treating you? _____

How did you hear about our practice? _____

Height: _____ Weight: _____

Do you have any illnesses or medical conditions? _____ Yes _____ No

If yes, please list them: _____

Have you had any of the following?

Cancer _____ Yes _____ No

Heart Disease _____ Yes _____ No

Diabetes _____ Yes _____ No

Hepatitis _____ Yes _____ No

High Blood Pressure _____ Yes _____ No

High Cholesterol _____ Yes _____ No

Arthritis _____ Yes _____ No

Asthma _____ Yes _____ No

Myocardial Infarct _____ Yes _____ No

Have you ever been hospitalized? If yes, list when and why: _____

Have you ever had any surgery? If yes, please list type of surgery and year: _____

Have you ever had a blood transfusion? _____ Yes _____ No

Medications: List all of your medications and doses:

Example:

Name

Dose

How often do you take it?

Tylenol

650 mgs

Four times a day

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

List any vitamins, herbs, supplements or over-the-counter medications you take, even if you use them rarely:

Allergies:

Do you have any allergies to medications? _____ Yes _____ No If yes, what? _____

Do you have any allergies to food? _____ Yes _____ No If yes, what? _____

Family History:

Do any of your family members have or did they have in the past:

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sudden Cardiac Death	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details regarding health of your family

	Age or	Age at Death	Medical Problems or cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____

Social History?

	<u>Currently</u>	<u>Previous</u>
Do you now smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how much do you/did you smoke?	_____	
If you previously smoked, when did you quit?	_____	
Does anyone you live with or work with smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how many glasses per day/week do you drink?	_____	
Do you think drugs or alcohol caused a problem in your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use any drugs (i.e. marijuana, cocaine or heroin)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever used illicit drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any religious or cultural beliefs that you doctor should know about before beginning medical treatment? Yes No

How would you describe the place where you live: House/Apartment Group Home Nursing Home Shelter No Stable Housing

Are you: Single Married Widowed Divorced With a partner Any Children? _____

What kind of work do you do? _____

What is the last grade you completed? _____

Do you exercise on a regular basis? _____

How would you describe your diet? _____

Do you every worry about not having enough money to buy medications? Yes No

Review of Systems Do you have or have you had in the recent past any of the following:

Consitutional:

Recent weight change of more than 10 lbs. Yes No

Decreased appetite Yes No

Excessive sweating Yes No

Fatigue/weakness Yes No

Difficulties sleeping Yes No

Endocrine:

Goiter now or in the past Yes No

Bothered excessively by hot or cold weather Yes No

High blood sugar Yes No

Frequent fevers/night sweats Yes No

Special Diet Yes No

Thirsty most of the time Yes No

Eyes:

Pain/Redness Yes No

Blurred or double vision Yes No

Hematologic/Lymphatic:

Bleeding/bruising easily Yes No

Lumps in neck, arm pits or groin Yes No

Burning/itching/watery eyes Yes No

Ears, Nose and Throat

Difficulty hearing Yes No

Nose Bleeds Yes No

Chronic recurrent sore throat Yes No

Hoarseness Yes No

Dental problems Yes No

Respiratory

Chronic/frequent coughs Yes No

Shortness of breath Yes No

Coughing up blood Yes No

Wheezing Yes No

Snoring Yes No

Cardiovascular

Palpitations Yes No

Chest pain/tightness Yes No

Fainting Yes No

Swelling of feet or legs Yes No

Irregular heart beat Yes No

Heart murmur Yes No

Unable to climb 2 flights of stairs Yes No

Gastrointestinal

Black or bloody stools Yes No

Hemorrhoids Yes No

Nausea/Vomiting Yes No

Diarrhea Yes No

Constipation or use of laxatives Yes No

Change in bowel habits Yes No

Abdominal pain/heartburn Yes No

Genitourinary

Frequent urination Yes No

Urinating more than once a night Yes No

Burning or pain on urination Yes No

Blood in urine Yes No

Difficulty holding urine Yes No

Sexual dysfunction Yes No

Low blood count in past Yes No

Allergic/Immunologic

Recurrent Infections Yes No

Allergies or hay fever Yes No

Neurological

Frequent or chronic headaches Yes No

Muscle weakness Yes No

Convulsions/seizures Yes No

Memory problems Yes No

History of stroke/ mini strokes Yes No

Psychiatric

Hospitalized for mental or nervous disorder Yes No

Depressed or sad Yes No

Nervous or anxious Yes No

Excessive stress Yes No

Sleep problems Yes No

Musculoskeletal

Painful or swollen joints Yes No

Trouble with your back Yes No

Difficulty or pain with walking Yes No

Muscle pain Yes No

Skin

Rashes or itching Yes No

Change in skin color Yes No

MD's Comments: _____

Advance Directives:

Do you have: _____ Healthcare Proxy _____ Living Will _____ Advance Directives _____ Other

Functional Assessment:

Do you use any equipment to assist in your daily life? (i.e., cane, walker, oxygen tank) Yes No

If so, please list: _____

Patient Signature: _____

Print Name

Signature

Date

Provider Signature: _____