

Comprehensive Cardiology of Stamford and Greenwich

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We ask that all patients fill out this form at the time of each **follow-up visit**. 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: _____

Medical History

Has anything changed since your last visit? _____

Have you had any blood test or other tests perform within the last month? if yes, what tests and where? _____

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

Constitutional

Recent weight change >10lbs Yes No
Fatigue/weakness Yes No
Difficulties sleeping Yes No
Discontinuation of exercise Yes No
Bleeding/bruising easily Yes No

Eyes, Ears, Nose and Throat

Nose Bleeds Yes No
Chronic or recurrent sore throat Yes No
Blurred or double vision Yes No

Respiratory

Chronic/frequent coughs Yes No
Shortness of breath Yes No
Wheezing Yes No
Snoring Yes No

Cardiovascular

Palpitations Yes No
Chest pain/tightness Yes No
Fainting/Lightheadedness Yes No
Swelling of feet or legs Yes No
Decrease in exercise ability Yes No

Gastrointestinal

Abdominal pain/heartburn Yes No
Black or bloody stools Yes No
Nausea/Vomiting Yes No
Diarrhea Yes No

Genitourinary

Frequent urination Yes No
Burning or pain on urination Yes No
Difficulty holding urine Yes No
Sexual dysfunction Yes No

Musculoskeletal

Muscle pain Yes No
Muscle weakness Yes No
Difficulty or pain with walking Yes No
Recent Falls: Yes No

Neurological

Memory problems Yes No
Frequent or chronic headaches Yes No

Mood:

Over the past two weeks have you been bothered by any of the following problems?

Not at all- 0, Several Days-1, More than half of the days-2, Nearly every day-3

Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble sleeping, Can't stay a sleep				
Or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself	0	1	2	3
Trouble concentrating on things	0	1	2	3
Moving or speaking slowly or				
Being fidgety or restless	0	1	2	3
Thoughts that you would be better				
off dead or of hurting yourself	0	1	2	3

If you have had any any of these problems how difficult have those problems made it for you to work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult
 Very difficult Extremely difficult

Patient Signature and Date

Physician Signature and Date