

Weill Cornell Medical College

## HeartHealth

A Program of the Dalio Institute of Cardiovascular Imaging

# NEW PATIENT VISIT QUESTIONNAIRE

Name:	Date of Birth: / /
Address: City	/: State: Zip:
Home Phone #:	Work Phone #:
Cell #:	Email:
Preferred Method of Communication:  My Chart	Email 🗆 Cell 🗆 Work 🗆 Home
Primary Care Physician:	
Office Address:	
Tel #:	Fax #:
Referring Physician (if different):	
Office Address:	
Tel #:	Fax #:
Pharmacy:	
Address:	
Tel #:	Fax #:
Medication prescription preference (circle one): $\Box$	30 day supply 🛛 90 day supply
Will you need translation services during your visit? If yes, please list the language required:	□ Yes □ No

Please note: We strongly recommend an English-speaking family member accompany you to your visit.

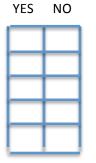
Why are you here to see a cardiologist today? Please be as specific as possible (e.g., symptoms or tests.)

#### PAST MEDICAL HISTORY:

Do you personally have a history of:

Known coronary artery disease?

- "silent" heart attack (found incidentally)
- heart attack(s) requiring hospitalization
- coronary artery stenting
- coronary artery ballooning only
- coronary artery bypass surgery



DETAILS (e.g., dates, hospitals, treating physicians)

1305 York Avenue, 8<sup>th</sup> Floor, New York, NY 10021 Telephone: 646-962-HART (4278) Fax: 646-962-0188

Heart rhythm disorders?		
- pacemaker?		
- defibrillator (ICD)?		
- atrial fibrillation?		
- atrial flutter?		
<ul> <li>ventricular arrhythmias?</li> <li>cardioversion?</li> </ul>		
- ablation procedure?		
Heart failure?		
A heart murmur?		
Mitral valve prolapse?		
Rheumatic heart disease?		
High blood pressure (even if treated)?		
High cholesterol (even if treated)?		
Diabetes (even if treated)?		
Stroke?		
Aortic aneurysm (an enlarged aorta)?		
Thyroid disorder (hyper or hypo)?		
Asthma/Emphysema/COPD?		
Stomach/peptic ulcers?		
Gastrointestinal bleeding?		
Heartburn/Reflux (GERD)?		
Lung cancer?		
Colon cancer?		
Breast cancer?		
Prostate cancer?		
History of a blood clot (DVT/PE)?		
Bleeding disorder?		
PAST SURGICAL HISTORY (Cardiac):		
Heart valve repair?		
Heart valve replacement?		
Carotid artery surgery (endarterectomy)?		
Aortic aneurym repair/stenting?		
Peripheral artery bypass surgery?		
Congenital heart disease repair of:	<u> </u>	
- Tetralogy of Fallot		
- atrial septal defect		
- ventricular septal defect		
·	<u> </u>	

Have you ever had non-cardiac surgery before? $\hfill\square$	Yes	🗌 No
If yes, please indicate <b>dates and types</b> of surgery:		

Do you curre Did you ever (If yes to any	use chewing	g tobacco (		Yes	ever smoke? No nount per day	□ Yes		No nd quit date	e.)
Do you curre (If yes, pleas			No cohol and a	pproximate	number of <u>dr</u>	inks per we	eek for eac	ch type.)	
Are you:	Married		Single	🗌 Divo	orced	🗆 Wi	dowed	🗆 Ot	her
Do you curre	ently work?		Yes 🗌	No O	ccupation:				
Please indica	ate your fami	ily membe	rs' medical	history as b	elow:				
	First Name	Alive? (Y/N)	Age	Heart Disease?	High Cholesterol?	Diabetes?	Stroke?	Cancer?	Emphysema or asthma?
Father		( ) /	0-						
Mohter									
Brothers									
Sister(s)									
(com/c)									
Son(s)									
Daughter(s)									
Daughter(3)									
Other(s)									
. ,									
belo	w (e.g., hear	t attack, st	tents, bypa	ss surgery, v	or heart disea alve disease, Iddenly please	atrial fibrill	ation, etc.)	) as well as	the age of

was heart-related (e.g., heart attack, sudden death, stroke, etc.)

Do you have a living will?		Yes		No	
Do you have a health care pr	oxy?		Yes		No If yes, please list contact information below:
Name:					Relation:
Address:					
Home Phone #:					Cell Phone #:
Work Phone #:					Fax # (if applicable):
E-mail address:					

Please list ALL of your CURRENT medications below (if you need more room please use back of page):

Medication (name)	Amount	Frequency taken (daily, every 6 hours, etc.)	Approximate start Date of Medication
Example: metoprolol	25 mg	Once daily	2005

Do you take any non-pres If yes, please list below:	scription medications?	Yes	No

Yes

Do you have any ALLERGIES to medications? If yes, please list medications and reactions: 🗌 No

NO

**REVIEW OF SYSTEMS:** Please indicate **IF YOU ARE** <u>CURRENTLY</u> **EXPERIENCING** any of the following signs and/or symptoms:

	YES	NO		YES
CONSTITUTIONAL			MUSCULOSKELETAL	
Recent change in weight?			Pains in the joints (knees, hips, etc.)?	$\vdash$
Fevers?			Muscle pains?	
Chills?			Bone fractures?	
Night sweats?			Pain in the bones (not joints)?	
Decreased appetite?			GENITOURINARY	
Fatigue?			Need to urinate frequently?	
Inability to sleep?			Need to urinate suddenly and urgently?	

#### YES NO

#### YES NO

#### EYES

Recent change in vision?

Double vision?

Eye pain?

### EARS/NOSE/MOUTH/THROAT

Hearing I	oss?
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Ringing in the ears?

Pain in the ears?

Nasal congestion?

Runny nose?

Post nasal drip?

Nosebleeds?

Sore throat?

### CARDIOVASCULAR

Chest pains?

Palpitations?

Inability to sleep lying flat?

Swelling in the legs or feet?

Muscle pains in the legs with walking?

Awakening feeling short of breath?

Lightheadedness?

Loss of consciousness?

Decreasing exercise tolerance?

#### RESPIRATORY

Shortness of breath?

Coughing up sputum/phlegm?

Coughing up blood?

Wheezing?

#### GASTROINTESTINAL

Nausea?
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Vomiting?

Abdominal pains?

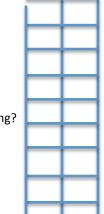
Diarrhea?

Constipation?

Heartburn/reflux?

Blood in the stool?





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Frequent urination at night (>1X)?
Blood in the urine?
Pain while urinating?
Urinary incontinence?

## DERMATOLOGICAL

New rashes?

New ulcers?

Recent hair loss?

Recent change in skin?

#### NEUROLOGICAL

New weakness?

New severe headaches?

New memory loss?

New seizures?

Sensation of the world spinning?

#### ENDOCRINOLOGIC

New intolerance to heat? New intolerance to cold? Increased frequency of urination? Increased need to drink fluids?

#### HEMATOLOGICAL

Easy bleeding?

Easy bruising?

Swollen glands/lymph nodes?

Current use of coumadin/Pradaxa/Xarelto?

### ALLERGIC/IMMUNOLOGIC

Diffuse itching?

Anaphylaxis?

Swelling of the throat?

#### PSYCHIATRIC

Depressed mood? Inability to enjoy anything? Anxiety? Suicidal thoughts? Hallucinations?

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