Weill Cornell Medical College

NewYork-Presbyterian
Weill Cornell Medical Center

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): ☐ 30 day supply ☐ 90 day supply

Will you need translation services during your visit? ☐ Yes ☐ No
If yes, please list the language required: _____

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:

	YES	NO	DETAILS (e.g., dates, hospitals, treating physicians)
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			

	YES	NO	DETAILS (e.g., dates, hospitals, treating physicians)
Heart rhythm disorders?			
- pacemaker?			
- defibrillator (ICD)?			
- atrial fibrillation?			
- atrial flutter?			
- ventricular arrhythmias?			
- cardioversion?			
- 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:			
- Tetralogy of Fallot			
- atrial septal defect			
- ventricular septal defect			

Have you ever had non-cardiac surgery before? ☐ Yes ☐ No
If yes, please indicate **dates and types** of surgery:

Do you currently smoke? ☐ Yes ☐ No Did you ever smoke? ☐ Yes ☐ No
Did you ever use chewing tobacco or snuff? ☐ Yes ☐ No
(If yes to any question, please indicate type of tobacco, amount per day, number of years, and quit date.)

Do you currently drink? ☐ Yes ☐ No
(If yes, please indicate type(s) of alcohol and approximate number of drinks per week for each type.)

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Do you currently work? ☐ Yes ☐ No Occupation:

Please indicate your family members' medical history as below:

	First Name	Alive? (Y/N)	Age	Heart Disease?	High Cholesterol?	Diabetes?	Stroke?	Cancer?	Emphysema or asthma?
Father									
Mohter									
Brothers									
Sister(s)									
Son(s)									
Daughter(s)									
Other(s)									

For any family member you have indicated "yes" for heart disease above, please list the specific details below (e.g., heart attack, stents, bypass surgery, valve disease, atrial fibrillation, etc.) as well as the age of onset of the disease. If any family member died suddenly please indicate the age at death and if the cause was heart-related (e.g., heart attack, sudden death, stroke, etc.)

Family member	Age at onset/death	Type of heart disease/Cause of death

Do you have a living will? ☐ Yes ☐ No

Do you have a health care proxy? ☐ 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-prescription medications? ☐ Yes ☐ No

If yes, please list below: _____

_____

_____

Do you have any ALLERGIES to medications? ☐ Yes ☐ No

If yes, please list medications and reactions: _____

_____

_____

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

	YES	NO
CONSTITUTIONAL		
Recent change in weight?	☐	☐
Fevers?	☐	☐
Chills?	☐	☐
Night sweats?	☐	☐
Decreased appetite?	☐	☐
Fatigue?	☐	☐
Inability to sleep?	☐	☐

	YES	NO
MUSCULOSKELETAL		
Pains in the joints (knees, hips, etc.)?	☐	☐
Muscle pains?	☐	☐
Bone fractures?	☐	☐
Pain in the bones (not joints)?	☐	☐
GENITOURINARY		
Need to urinate frequently?	☐	☐
Need to urinate suddenly and urgently?	☐	☐

	YES	NO
EYES		
Recent change in vision?		
Double vision?		
Eye pain?		
EARS/NOSE/MOUTH/THROAT		
Hearing loss?		
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?		
Vomiting?		
Abdominal pains?		
Diarrhea?		
Constipation?		
Heartburn/reflux?		
Blood in the stool?		

	YES	NO
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?		