Weill Cornell Medical College

NewYork-Presbyterian
Weill Cornell Medical Center

HeartHealth
A Program of the Dalio Institute of Cardiovascular Imaging

HeartHealth – New Patient Visit Questionnaire

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**.

Patient Name:			**Date of Visit:**
Date of Birth:	***Home Phone:***	***Work Phone:***	***Cell:***
Preferred email:			
Address:			
Preferred Method of Communication: ❑ CONNECT ❑Cell ❑Work ❑Home ❑Email			

PHYSICIAN AND PHARMACY INFORMATION	
Primary Care Provider (Name/Address/Phone/Fax):	**Referring Physician** (Name/Address/Phone/Fax): ❑ Same as PCP
Other Physician to send records to (Name/Address/Phone/Fax):	**Other Physician to send records to** (Name/Address/Phone/Fax):
Specialty:	Specialty:
Preferred Pharmacy (Name/Address/Phone/Fax):	
Medication prescription preference (select one)**:** ❑ 30 day supply ❑ 90 day supply	

Reason/s For Visit:

MEDICAL HISTORY			
Do you personally have a history of:	**Yes**	**No**	**Details: (e.g. date, hospitals, treating physician**
Known coronary artery disease?			
"Silent" heart attack (found incidentally)?			
Heart attack(s) requiring hospitalization?			
Coronary artery stenting?			
Coronary artery ballooning only?			
Heart rhythm disorders?			
Pacemaker?			
Defibrillator (ICD)?			

Do you personally have a history of:	Yes	No	Details: (e.g. date, hospitals, treating physician)
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)?			
Sleep Apnea?			
Hypo Thyroid Disorder?			
Hyper Thyroid Disorder?			
Asthma?			
Emphysema?			
COPD?			
Stomach/peptic ulcers?			
Gastrointestinal bleeding?			
Heartburn/Reflux (GERD)?			
Any cancer?			
Headache/migraine?			
History of blood clot (DVT/PE)?			
Bleeding disorder?			
Other (please list):			

PAST SURGICAL HISTORY (Cardiac)			
	Yes	**No**	**Details: (e.g. date, hospitals, treating physician)**
Coronary artery bypass surgery (CABG)?			
Heart valve repair?			
Heart valve replacement?			
Carotid artery surgery (endarterectomy)?			
Aortic aneurysm repair/stenting?			
Peripheral artery bypass surgery?			
Congenital heart disease repair of:			
Tetralogy of Fallot?			
Atrial septal defect?			
Ventricular septal defect?			

PAST SURGICAL HISTORY (Non-cardiac)		
Surgical Type	**Dates**	**Reason**

SOCIAL HISTORY

Do you drink **alcohol**?	Do you **smoke**?	Do you use recreational **drugs**?
❑ Never ❑ Yes. I drink ❑ wine ❑ beer ❑ liquor ❑ I have _____ drink(s) per week ❑ I used to drink but quit in _____ (year)	❑ I never smoked ❑ Yes. I smoke ❑ cigarettes ❑ cigars ❑ pipes. ❑ I currently smoke and I don't want to quit ❑ I currently smoke but I'm ready to quit. ❑ I smoke _____ pack(s) per day for _____ years ❑ I used to smoke but quit in _____(year) ❑ I use chewing or smokeless tobacco	❑ Never ❑ No, but I have used _____ ❑ Yes, I use _____
Are you: ❑ Married ❑ single ❑ Divorced ❑ Widowed ❑ Other		Do you currently work? ❑ Yes ❑ No Occupation:
Do you **exercise**? ❑ Yes ❑ No		**If yes, how often and what type?**

FAMILY HISTORY

Father	Mother	Sibling	Sibling
Name: **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:	**Name:** **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:	**Name:** **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:	**Name:** **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:
Sibling	**Children**	**Children**	**Other Relative**
Name: **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:	**Name:** **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:	**Name:** **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:	**Name:** **Age:** ❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Cancer (Type:) ❑ Emphysema or asthma ❑ Other:

For any family you have indicated “yes” for heart disease above, please list the specific details below (e.g. heart attack, stents, bypass surgery, valve disease, artial fibrillation, etc.) as well as the age of onset of the disease. If any family member died suddenly please indicate the age of 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

ALLERGIES AND MEDICATIONS

ALLERGIES

Allergies (Medication, Food, Cosmetics, Etc.)	Cause/Nature of Reaction

MEDICATIONS

Medications/Supplements	Dosage/Frequency	Condition/Reason	Approximate Start Date of Medication

REVIEW OF SYSTEMS

(Please indicate if YOU ARE CURRENTLY EXPERIENCING any of the following signs and/or symptoms)

Constitutional
❑ Normal
Y N
☐☐ Recent change in weight
☐☐ Fever
☐☐ Chills
☐☐ Night sweats
☐☐ Decreased appetite
☐☐ Fatigue
☐☐ Inability to sleep

Eyes
❑ Normal
Y N
☐☐ Contact lenses or glasses
Type: _____
☐☐ Recent change in vision
☐☐ Double vision
☐☐ Eye pain

Ears/Nose/Mouth/Throat
❑ Normal
Y N
☐☐ Hearing loss
☐☐ Ringing in the ears
☐☐ Pain in the ears
☐☐ Nasal congestion
☐☐ Runny nose
☐☐ Post nasal drip
☐☐ Nosebleeds
☐☐ Soar throat

Cardiovascular
❑ Normal
Y N
☐☐ 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
☐☐ Lightdeadedness
☐☐ Loss of consciousness
☐☐ Decreasing exercise tolerance

Respiratory
❑ Normal
Y N
☐☐ Shortness of breath
☐☐ Coughing up sputum/phlegm
☐☐ Coughing up blood
☐☐ Wheezing

Gastrointestinal
❑ Normal
Y N
☐☐ Nausea
☐☐ Vomiting
☐☐ Abdominal pains
☐☐ Diarrhea
☐☐ Constipation
☐☐ Heartburn/reflux
☐☐ Blood in the stool

Musculoskeletal
❑ Normal
Y N
☐☐ Pains in the joints
☐☐ Muscle pains
☐☐ Bone fractures
☐☐ Pain in the bones (not joints)

Genitourinary
❑ Normal
Y N
☐☐ Need to urinate frequently
☐☐ Need to urinate suddenly and urgently
☐☐ Frequent urination at night (>1)
☐☐ Blood in urine
☐☐ Pain while urinating
☐☐ Urinary incontinence

Dermatological
❑ Normal
Y N
☐☐ New rashes
☐☐ New ulcers
☐☐ Recent hair loss
☐☐ Recent change in skin

Neurological
❑ Normal
Y N
☐☐ New weakness
☐☐ New severe headaches
☐☐ New memory loss
☐☐ New seizures
☐☐ Sensation of the world spinning

Endocrinologic
❑ Normal
Y N
☐☐ New intolerance to heat
☐☐ New intolerance to cold
☐☐ Increased frequency of urination
☐☐ Increased need to drink fluids

Hematologic
❑ Normal
Y N
☐☐ Easy bleeding
☐☐ Easy bruising
☐☐ Swollen glands/lymph nodes
☐☐ Current use of Coumadin/Pradaxa/Xarelto

Allergic/immunologic
❑ Normal
Y N
☐☐ Diffuse itching
☐☐ Anaphulaxis
☐☐ Swelling of the throat

Psychiatric
❑ Normal
Y N
☐☐ Depressed mood
☐☐ Inability to enjoy anything
☐☐ Anxiety
☐☐ Suicidal thoughts
☐☐ Hallucinations

Sleep
❑ Normal
Y N
☐☐ Snoring
☐☐ Sleep Apnea
☐☐ CPAP/BiPAP/AutoPAP
☐☐ Insomnia
☐☐ Choking/Gasping
☐☐ Restless leg
☐☐ Daytime sleepiness

How did you hear about us?
❑ Physician ❑ Family/Friend ❑ Internet ❑ Health Plan ❑ Advertisement ❑ Referral Service ❑ Weill Cornell Connect ❑ Int'l Office

The information is accurate and complete to the best of my knowledge.
I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.

Patient Signature: Name of person completing form (if not patient): Signature: Today's Date:	Physician Signature: Today's Date:

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