

NEW PATIENT EVALUATION

Name: _____

Date Of Visit: ___/___/___ REFERRING PHYSICIAN: _____ DOB: ___/___/___

Please answer the following questions prior to your visit with the doctor. This will assist greatly in your evaluation and care.

Please describe briefly the main symptoms that led to your referral to the cardiologist:

How long have these symptoms been occurring:

Do you have any of the following symptoms?

	YES	NO		YES	NO
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Feet/ankles swelling	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath at rest	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain or cramps when walking	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath with exertion	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain or cramps at rest	<input type="checkbox"/>	<input type="checkbox"/>
Do you awaken at night short of breath?	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
How many pillows do you sleep on? _____			Clots in legs (DVT)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dizzy spells?	<input type="checkbox"/>	<input type="checkbox"/>	Nonhealing wounds in legs/feet	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lightheadedness with			Cough	<input type="checkbox"/>	<input type="checkbox"/>
Sudden standing?	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged standing?	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Bending over?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever fainted?			Impotence/erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your heart pounding or racing?	<input type="checkbox"/>	<input type="checkbox"/>			
How often? _____					
How long does it last? _____					

Please circle all medical conditions you have presently or have had in the past:

Heart Attack	Diabetes	Valve Replacement
Arrhythmia	High Cholesterol	Acid reflux/Hiatal hernia
Stroke	Sleep apnea	Thyroid disease
High Blood Pressure	Bypass Surgery	

Please list below any drug allergies you have:

Are you allergic to: Aspirin Yes No CT/X-ray (dye) Yes No
 Other: _____

Please list below any member of your immediate family who has ever had a heart attack, diabetes, angioplasty or bypass surgery, cardiac arrhythmia, sudden death. Please list the ages of any immediate family member who have died and the cause.

Mother - _____ Brother(s) - _____
 Father - _____ Sisters(s) - _____

Please list below all surgeries you have had:

HABITS:

	YES	NO	HOW MUCH/HOW LONG?
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If you do not currently smoke or chew tobacco, have you ever done so?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How much per day or week of each? List all that apply:	<input type="checkbox"/>	Wine	_____
	<input type="checkbox"/>	Beer	_____
	<input type="checkbox"/>	Spirits	_____
Do you drink caffeinated beverages?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Marital status: (circle one) Single Married Divorced Widowed

Do you have children? How Many? _____

Are you currently employed? _____

What is your occupation? _____

NAME: _____

Please check "yes" or "no" to the following listed symptoms or problems or fill in the blanks when necessary

CONSTITUTIONAL	YES	NO	GENITO-URINARY	YES	NO
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Prostate disease (males)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Blood in the urine	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>
Sleepiness during the day	<input type="checkbox"/>	<input type="checkbox"/>	GYNECOLOGICAL (females)		
EYES			Hysterectomy (females)	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive vaginal bleeding (females)	<input type="checkbox"/>	<input type="checkbox"/>
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	Post-menopausal (females)	<input type="checkbox"/>	<input type="checkbox"/>
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? (females)	<input type="checkbox"/>	<input type="checkbox"/>
EARS, NOSE, MOUTH, AND THROAT			Last menstrual period _____ (females)		
Decrease in hearing	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
Ringling of the ears	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Tooth ache/cavities	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Dental prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL		
GASTROINTESTINAL			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool or black stools	<input type="checkbox"/>	<input type="checkbox"/>	Weakness on one side	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or intestinal ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling on one side	<input type="checkbox"/>	<input type="checkbox"/>
Reflux disease or heartburn	<input type="checkbox"/>	<input type="checkbox"/>	SKIN		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
LIVER AND PANCREAS			Rash	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGICAL		
Pancreas disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Low platelets	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>