Account #:
Date:

Cardiovascular Specialists, P.C.

New Patient Form

Name: _________________________________ **Date of Birth** ___/___/___ **Age** _____

Referring Physician: _____________________________

Reason for this appointment: ____

____

Previous heart tests: (include date) Stress test ______ Cardiac catheterization _____
Echocardiogram ______ Heart monitor ______ Chest x-ray ______

Personal History: Which of the following conditions are you currently being treated for or have been treated for in the past? (check those that apply)

__ high blood pressure	__ irregular heart rhythm	__ depression
__ diabetes	__ fainting	__ thyroid problems
__ coronary artery disease	__ stroke or mini-stroke	__ HIV/AIDS
__ heart attack	__ asthma	__ cancer
__ heart failure	__ lung problems	__ arthritis
__ high cholesterol	__ kidney problems	__ anemia/blood disorder
__ rheumatic fever	__ stomach ulcer	__ liver problems
__ heart murmur	__ indigestion/reflux	__ OTHER (explain below)

____

____

Past Surgeries: (include date)

___________________ ___________________ ___________________

___________________ ___________________ ___________________

Account #

Family History: (list their current or past medical problems)

Mother ____

Father____

Siblings ____

Children ____

Any family history of heart disease, heart attacks, or sudden death? Yes / No

Social History: married___ single ___ divorced ___How many children? ___

Occupation ____

Exercise Frequency ____

Caffeine: (drinks/day) _________

Alcohol: (drinks/day) __________

Smoking: (packs/day) ______ for how long? ___________

Illicit drug use: Yes / No

Medications:

Name	Dose	Times per day

ALLERGIES: (please list medication name and your reaction to the medication)

Account #

Review of Systems: (check any symptoms that recently apply to you)

Constitutional

__ fever/chills

__ fatigue

__ weight change

__ dizziness

Respiratory

__ shortness of breath

__ wheezing

__ cough

Musculoskeletal

__ muscle aches

__ arthritis/gout

__ back/neck pain

Eyes

__ contact lenses

__ glasses

__ vision change

Gastrointestinal

__ nausea/vomiting/diarrhea

__ heartburn/indigestion

__ blood in stool

Nervous system

__ tingling

__ numbness

__ extremity weakness

__ seizures

Ears/Nose/Throat

__ hearing aids

__ sinus congestion

__ allergies

__ nosebleeds

Genitourinary

__ frequent urination

__ impotence

__ decreased sex drive

__ last menstrual period ________

Skin

__ rash

__ easy bruising

Cardiovascular

__ chest pain

__ palpitations

__ leg swelling

__ shortness of breath

__ fainting

Endocrine

__ excessively hot or cold

__ increased thirst

__ night-time urination