Weill Cornell Medicine
Cardiology

NEW PATIENT VISIT QUESTIONNAIRE

Name:_____ Date of Birth: ____/____/____
Home Phone #:_____ Cell Phone #:_____
Work Phone #:_____ Fax #:_____
Address:_____City: _____State:_____Zip:_____

Primary Care Physician:_____
Office Address:_____
Work #:_____ Fax #:_____
Referring Physician (if different):_____
Office Address:_____
Work #:_____ Fax #:_____

Pharmacy:_____
Address:_____
Phone #:_____ 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.)

_____
_____
_____

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

_____
_____
_____

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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			
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:			
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			

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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									
Mother									
Brother(s)									
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:_____

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

If yes, please list medications and reactions: _____

_____

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: _____

_____

_____

_____

_____

_____

_____

_____

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REVIEW OF SYSTEMS: Please indicate **IF YOU ARE CURRENTLY 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?		
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
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?		
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?		