Weill Cornell Medicine NewYork-Presbyterian
Cardiothoracic Surgery

PULMONOLOGY AND THORACIC PATIENT INITIAL VISIT FORM

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

Patient's Name	Patient's Date of Birth:
Patient's Mobile Phone #:	Patient's Preferred Email:
Patient's Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner	
Patient's Spouse/Significant Other:	Patient's Occupation / Patient's Language Preference

How were you referred to us?	☐ WEBSITE ☐ HEALTH PLAN DIRECTORY ☐ FAMILY/FRIEND ☐ PHYSICIAN ☐ INTERNET ☐ PHYSICIAN REFERRAL SERVICE ☐ CORNELL WEBSITE ☐ INTERNATIONAL OFFICE ☐ OTHER Please Specify: _____		
Referring Physician's Full Name ❑ Not Applicable		Phone	Fax:
Address:			
Primary Care Physician's Full Name ❑ Not Applicable		Phone	Fax:
Address:			
Pulmonologist's Full Name ❑ Not Applicable		Phone	Fax:
Address:			
Oncologist's Full Name ❑ Not Applicable		Phone	Fax:
Address:			
Gastroenterologist's Full Name ❑ Not Applicable		Phone	Fax:
Address:			
Cardiologist's Full Name ❑ Not Applicable		Phone	Fax:
Address:			

Other Doctors You Want Your Records Sent To (Physician Name, Full Address, Phone#)

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Health Information:

Reason for today's visit:
Other diseases and / or problem:

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

	Yes or No	If Yes, When?		Yes or No	If Yes, When?
Angina	❑ Y ❑ N		Pneumonia	❑ Y ❑ N	
Angioplasty	❑ Y ❑ N		Acid Reflux	❑ Y ❑ N	
Arrhythmia	❑ Y ❑ N		Barrett's Esophagus	❑ Y ❑ N	
Heart Attack	❑ Y ❑ N		Ulcers	❑ Y ❑ N	
Congestive Heart Failure	❑ Y ❑ N		Diabetes	❑ Y ❑ N	
Coronary Artery Disease	❑ Y ❑ N		Thyroid Disorder	❑ Y ❑ N	
Mitral Valve Prolapse	❑ Y ❑ N		Liver Disease	❑ Y ❑ N	
High Blood Pressure	❑ Y ❑ N		Hepatitis/Jaundice	❑ Y ❑ N	
High Cholesterol	❑ Y ❑ N		Kidney Dysfunction	❑ Y ❑ N	
Atrial Fibrillation	❑ Y ❑ N		Dialysis	❑ Y ❑ N	
Stroke	❑ Y ❑ N		Cancer/Tumors	❑ Y ❑ N	
Seizure	❑ Y ❑ N		Arthritis/Joint Pain	❑ Y ❑ N	
Vascular Disease	❑ Y ❑ N		Depression/Anxiety	❑ Y ❑ N	
Deep Vein Thrombosis	❑ Y ❑ N		Glaucoma	❑ Y ❑ N	
Blood Clot in Lungs	❑ Y ❑ N		Leg Swelling	❑ Y ❑ N	
Blood Clot in Lungs	❑ Y ❑ N		Others / Comments		
Asthma	❑ Y ❑ N				
Emphysema/COPD	❑ Y ❑ N				
Tuberculosis	❑ Y ❑ N				

HAVE YOU EVERY HAD SURGERY? ❑ Yes ❑ No

(If yes, please list the type of surgery and when you had it done)

Have you ever been hospitalized for any reason other than surgery?

Social History:

Do you smoke? ❑ Yes ❑ No	Did you quit smoking? ❑ Yes ❑ No	If yes, when did you quit?	
How many packs a day?	❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Vaping	How many years?	
Do you drink alcohol? ❑ Yes ❑ No	Type of Alcohol:	How many drinks a week?	
Do you use recreational drugs? ❑ Yes ❑ No	If yes, please specify:	❑ IV ❑ Smoke ❑ Intranasal	
Do you exercise regularly? ❑ Yes ❑ No	How often?	What type of exercise?	
What is your Height?		What is your Weight?	

Last Blood Pressure (if known)

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Family History:

Please list any medical conditions: (specify history of cancer, heart disease, stroke, diabetes, etc.?)

Maternal Grandmother	Alive?	❑	Yes	❑	No	
Maternal Grandfather	Alive?	❑	Yes	❑	No	
Paternal Grandmother	Alive?	❑	Yes	❑	No	
Paternal Grandfather	Alive?	❑	Yes	❑	No	
Mother	Alive?	❑	Yes	❑	No	
Father	Alive?	❑	Yes	❑	No	
Sister	Alive?	❑	Yes	❑	No	
Brother	Alive?	❑	Yes	❑	No	
Daughter	Alive?	❑	Yes	❑	No	
Son	Alive?	❑	Yes	❑	No	
Other/Comments	Alive?	❑	Yes	❑	No	

REVIEW OF SYSTEMS *please check, if any of the following apply*

Constitutional	❑ Fatigue	❑ Insomnia	❑ Weight Change	❑ Fever	❑ Chills	❑Night Sweats
Eyes	❑ Vision Changes					
Ear, Nose, Throat #1	❑ Sore Throat	❑ Ringing in Ears (Tinnitus)			❑ Ear Pain	
Ear, Nose, Throat #2	❑ Nasal Congestion		❑ Difficulty in Swallowing			
Cardiovascular #1	❑ Chest Pain	❑ Palpitations	❑ Lightheaded	❑ Swelling (Edema)		
Cardiovascular #2	❑ Leg/Calf Pain	❑ Fainting	❑ Shortness of Breath			
Respiratory #1	❑ Sputum	❑ Blood in Sputum	❑ Coughing	❑ Wheezing	❑ Sleep Apnea	
Gastrointestinal #1	❑ Nausea	❑ Vomiting	❑ Diarrhea	❑ Abdominal Pain		
Gastrointestinal #2	❑ Constipation	❑ Dyspepsia	❑ Reflux	❑ Blood in Vomit		
Musculoskeletal	❑ Arthritis	❑ Myalgia		❑ Bone Pain		
Genitourinary	❑ Urinary Retention	❑ Incontinence	❑ Urgency	❑ Painful Urination		
Genitourinary	❑ Blood in Urine	❑ Urine Frequency	❑ Nocturia			
Integumentary	❑ Rashes	❑ Skin Ulcers	❑ Alopecia	❑ Skin Changes	❑ Itching	
Neurologic #1	❑ Weakness	❑ Memory Loss	❑ Convulsions			
Neurologic #2	❑ Vertigo	❑ Unusual Headaches	❑ Tremor			
Endocrine #1	❑ Blood Glucose Level	❑ Heat intolerance				
Endocrine #2	❑ Cold intolerance	❑ Excessive Urinating	❑ Excessive Thirst			
Hematology/Lymphatic	❑ Easy Bruising	❑ Easy Bleeding	❑ Swelling or enlarged lymph nodes			
Hematology/Lymphatic	❑ Anticoagulation use					
Allergy	❑ Hives	❑ Anaphylaxis	❑ Angioedema	❑ Raynaud's Disease		
Psychiatric	❑ Depression	❑ Anxiety	❑ Hallucination	❑ Suicidal ideation		

Immunizations

Did you have your Flu Vaccine?	Date		❑	Yes	❑ No
Did you have Pneumonia Vaccine?	Date		❑	Yes	❑ No

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.

Signature of Patient or Person completing the Form :	Date Signed
Name of Patient or Person completing form:	
Physician's Signature	Date Signed

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Enter Current Date: _____

Patient's Name	Date of Birth	Patient's Phone#	Person completing the form	Relationship to patient	Contact Phone#

PREFERRED PHARMACY

PHARMACY NAME	PHARMACY ADDRESS	PHARMACY PHONE NUMBER	PHARMACY FAX NUMBER

MEDICATIONS LIST

Please include PLAVIX, FISH OIL, COUMADIN, ASPIRIN OR any blood thinning medication

PRESCRIPTION MEDICATION				
Medication Name	Prescribing doctor's name	Purpose for medication	Dose (ex. 2mg, 1tsp)	How Often? (ex. 3x/day)

ALLERGIES

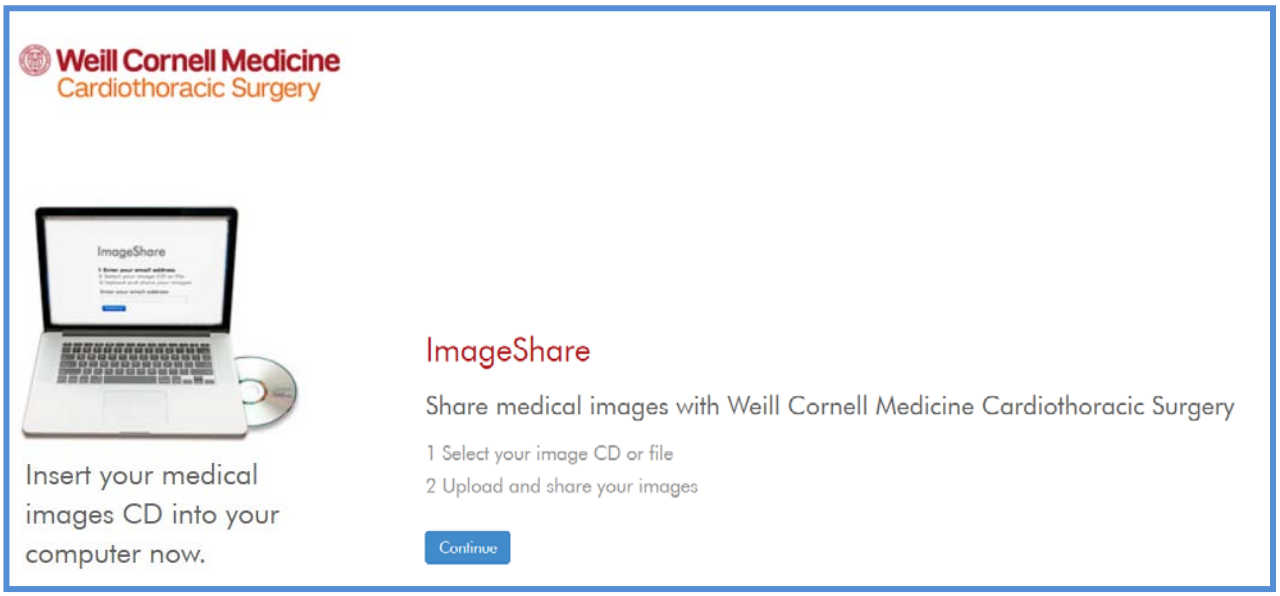
Name of Drug	Allergic Reaction

Notes

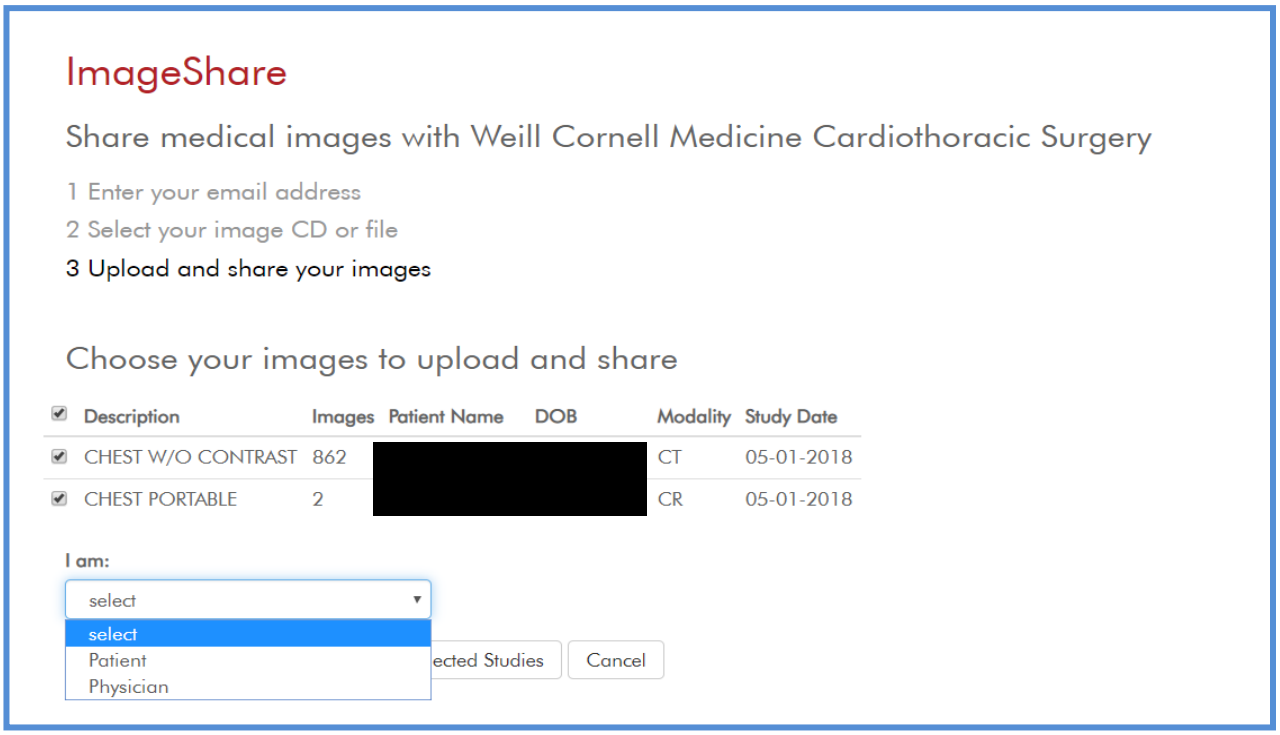
Ambra Upload Guide

Point your web browser to: **https://ctsurgery.weillcornell.org/uploads**

1. Click '**Continue**'



2. Click '**Choose files**', browse your computer for the image files. If the images are on a CD, they will likely be on the D drive. Upload the entire image folder. Allow the system to scan the files. Select whether you are a 'Patient' or a 'Physician' and fill out all the required fields. Then click '**Upload Selected Studies**'



3. After your study uploaded, you will receive a successful upload checkmark. You will then have the opportunity to '**Upload another study**', if needed.

Weill Cornell Connect

Your secure, online health connection

Urgent Medical Matters
Please **do not use** Weill Cornell CONNECT to send any messages requiring urgent attention. For urgent medical matters, contact your doctor's office by phone or call 911.

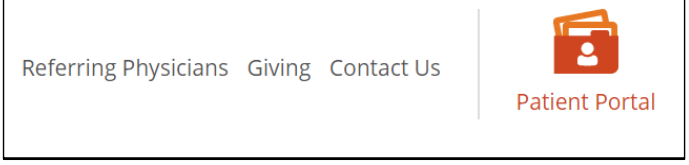
How to sign up Weill Cornell CONNECT patient portal:

You can sign up MyChart via internet using your laptop or desktop or Weill Cornell CONNECT app.

1. **To Sign up via Internet:**

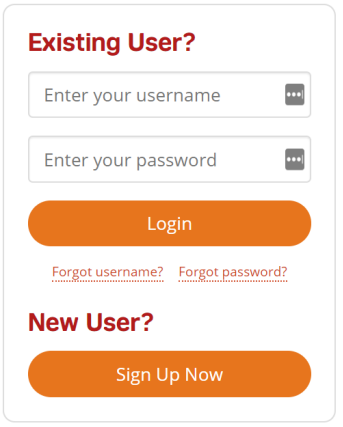
Go to: https://weillcornell.org/

Click on **Patient Portal** (Top Right of the Screen)



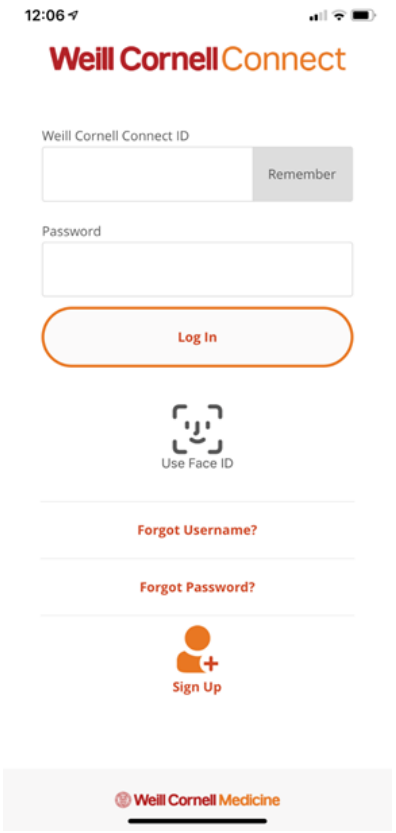
If you have an account please enter your username and password

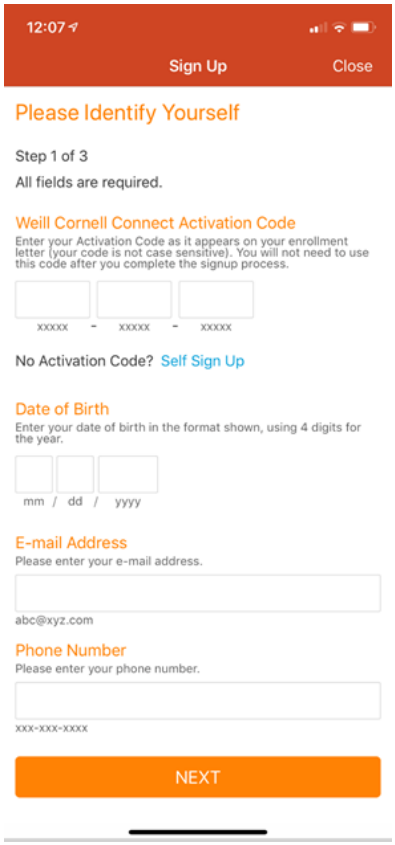
For New Users,
Click on Sign Up Now



2. To Sign Up via Weill Cornell Connect app:

You can download the Weill Cornell Medicine (WCM) app: Apple Store Google Play





Updated April 25, 2019