Weill Cornell Medicine NewYork-Presbyterian

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
Preferred Pharmacy (Name/Address/Phone/Fax):	
Medication prescription preference (select one)**:** ❑ 30 day supply ❑ 90 day supply	

What are the goals of your visit with us?
What questions would you like answered?

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)?			
Atrial fibrillation?			
Atrial flutter?			
Ventricular arrhythmias?			
Cardioversion?			
Ablation procedure?			

Do you personally have a history of:	Yes	No	Details: (e.g. date, hospitals, treating physician)
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?			
Hyper Thyroid disorder?			
Hypo 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?			
Chronic inflammatory condition?			
Lupus?			
Rheumatoid Arthritis?			
Inflammatory bowel disease?			
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**
Reproductive History (for Women)		
Age at first period		
How many pregnancies have you had?		
How many live births have you had?		
Have you reached menopause?	Yes❑ No❑	If yes, at what age?
Have you ever used hormone therapy?	Yes❑ No❑	
Have you ever had preeclampsia, gestational diabetes or hypertension?	Yes❑ No❑	

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:
What is the highest level of **education** you have completed?	❑ Elementary school or less ❑ Bachelor's degree ❑ High school ❑ Master's degree ❑ Some College ❑ Doctorate
Do you **exercise**? ❑ Yes ❑ No	**If yes, how often and what type?**

What do you eat and drink in a typical day? **Breakfast:**
Lunch:
Dinner:

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, atrial 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 (*Please include vitamins and any herbal supplements)			
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)

Constitution
❑ Normal
Y N
❑ ❑ Activity change
❑ ❑ Appetite Change
❑ ❑ Chills
❑ ❑ Sweating
❑ ❑ Fatigue
❑ ❑ Fever
❑ ❑ Unexpected weight change

HENT
❑ Normal
Y N
❑ ❑ Congestion
❑ ❑ Dental problem
❑ ❑ Drooling
❑ ❑ Ear discharge
❑ ❑ Ear pain
❑ ❑ Facial swelling
❑ ❑ Hearing loss
❑ ❑ Mouth sores
❑ ❑ Nosebleeds
❑ ❑ Postnasal drip
❑ ❑ Runny Nose
❑ ❑ Sneezing
❑ ❑ Sore throat
❑ ❑ Ringing in ears
❑ ❑ Trouble swallowing
❑ ❑ Voice change

Eyes
❑ Normal
Y N
❑ ❑ Eye discharge
❑ ❑ Eye itching
❑ ❑ Eye pain
❑ ❑ Eye redness
❑ ❑ Eye pain with bright light
❑ ❑ Visual disturbance

Respiratory
❑ Normal
Y N
❑ ❑ Apnea
❑ ❑ Chest tightness
❑ ❑ Choking
❑ ❑ Cough
❑ ❑ Shortness of breath
❑ ❑ Inability to task a deep breath
❑ ❑ Wheezing

Cardiovascular
❑ Normal
Y N
❑ ❑ Chest pain
❑ ❑ Leg Swelling
❑ ❑ Palpitations

GI
❑ Normal
Y N
❑ ❑ Abdominal bloating
❑ ❑ Abdominal pain
❑ ❑ Anal bleeding
❑ ❑ Blood in stool
❑ ❑ Constipation
❑ ❑ Diarrhea
❑ ❑ Nausea
❑ ❑ Rectal pain
❑ ❑ Vomiting

Endocrine
❑ Normal
Y N
❑ ❑ Cold intolerance
❑ ❑ Heat intolerance
❑ ❑ Increased thirst
❑ ❑ Increase in hunger
❑ ❑ Increase in urination

GU
❑ Normal
Y N
❑ ❑ Difficulty urinating
❑ ❑ Pain while urinating
❑ ❑ Inability to hold your urine
❑ ❑ Flank pain
❑ ❑ Frequency
❑ ❑ Genital Sore
❑ ❑ Blood in urine
❑ ❑ Urgency
❑ ❑ Urine decreased

Muscular
❑ Normal
Y N
❑ ❑ Joint pain
❑ ❑ Back pain
❑ ❑ Gait problem
❑ ❑ Joint swelling
❑ ❑ Muscle pain
❑ ❑ Neck pain
❑ ❑ Neck stiffness

Skin
❑ Normal
Y N
❑ ❑ Color change
❑ ❑ Pale
❑ ❑ Rash
❑ ❑ Wound

Allergy/Immuno
❑ Normal
Y N
❑ ❑ Environment allergies
❑ ❑ Food allergies
❑ ❑ Problems with your immune system

Neurological
❑ Normal
Y N
❑ ❑ Dizziness
❑ ❑ Facial asymmetry
❑ ❑ Headaches
❑ ❑ Lightheadedness
❑ ❑ Numbness
❑ ❑ Seizure
❑ ❑ Speech difficulty
❑ ❑ Fainting
❑ ❑ Tremors
❑ ❑ Weakness

Hematologic
❑ Normal
Y N
❑ ❑ Swollen glands
❑ ❑ Bruises easily

Psychiatric
❑ Normal
Y N
❑ ❑ Agitation
❑ ❑ Behavior problem
❑ ❑ Confusion
❑ ❑ Decreased concentration
❑ ❑ Feeling sad/depressed
❑ ❑ Hallucinations
❑ ❑ Hyperactive
❑ ❑ Nervous/anxious
❑ ❑ Self-injury
❑ ❑ Sleep disturbance
❑ ❑ Suicidal ideas

Mood

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things
- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Feeling down, depressed or hopeless
- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

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:

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