Weill Cornell Medicine NewYork-Presbyterian
Cardiothoracic Surgery

CARDIOLOGY AND CARDIAC SURGERY PATIENT INITIAL VISIT SELF-ASSESSMENT FORM

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, where 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#)

Health Information:

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

Social History:

Do you smoke? ☐ Yes ☐ No	Type ☐ Cigarette ☐ Cigars ☐ Pipe ☐ Smokeless Tobacco / Vaping	How many packs a day?	How many years?

Did you ever smoke? ☐ Yes ☐ No	Did you quit? ☐ Yes ☐ No	If yes, when did you quit?

Do you drink alcohol? ☐ Yes ☐ No	Type:	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 many minutes & day/weeks	What type of exercise?
What is your Height?	What is your Weight?	Last Blood Pressure?

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	

Immunizations

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

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

Constitutional	❑ Fatigue	❑ Activity Change	❑ Weight Change	❑ Fever	❑ Chills
Ear, Nose, Throat #1	❑ Sore Throat	❑ Ringing in Ears	❑ Ear Pain		
Ear, Nose, Throat #2	❑ Nasal Congestion	❑ Nose Bleed (Epistaxis)	❑ Mouth Sores		
Eyes	❑ Vision Changes	❑ Pain	❑ Floaters		
Respiratory #1	❑ Shortness of Breath during activity	❑ Shortness of Breath during rest	❑ Coughing		
Respiratory #2	❑ Chest Tightness	❑ Snoring	❑ Wheezing		
Cardiovascular #1	❑ Chest Pain	❑ Palpitations	❑ Swelling (Edema)	❑ Leg/Calf Pain	
Gastrointestinal #1	❑ Nausea	❑ Vomiting	❑ Diarrhea	❑ Constipation	❑ Difficulty Swallowing
Gastrointestinal #2	❑ Stomach Pain	❑ Vomiting Blood	❑ Blood in stool		
Endocrine #1	❑ Elevated Glucose Level	❑ Heat intolerance	❑ Cold intolerance		
Endocrine #2	❑ Excessive Urinating	❑ Excessive Thirst			
Genitourinary #1	❑ Blood in Urine	❑ Incontinence	❑ Urgency	❑ Painful Urination	
Genitourinary #2	❑ Erectile Dysfunction	❑ Nocturia	❑ Urine Frequency	❑ Urethral Discharge	
Musculoskeletal	❑ Aching Muscles	❑ Bone Pain			
Integumentary	❑ Rashes	❑ Skin Ulcers	❑ Hair Loss	❑ Skin Changes	
Allergy	❑ Food Allergies	❑ Environmental Allergies	❑ Immuno Compromised		
Neurologic #1	❑ Convulsions	❑ Vertigo	❑ Numbness		
Neurologic #2	❑ Tremor	❑Lightheaded/Dizziness	❑ Fainting	❑ Weakness	
Hematology/Lymphatic#1	❑ Easy Bruising	❑ Easy Bleeding	❑ Swelling or enlarged lymph nodes		
Psychiatric	❑ Hallucination	❑ Suicidal ideation	❑ Insomnia	❑ Agitation	
	❑ Confusion	❑ Sleep Disturbance			

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING

	YES	NO	Date		YES	NO	Date
Acute Arterial Occlusion				Low Platelets			
Anemia				COPD			
Angina				Pneumonia			
Angioplasty				Liver Disease			
Aortic Aneurysm and Dissection				Acid Reflux/GERD			
Arrhythmia				Home Oxygen Use			
Asthma				Hepatitis/Jaundice			
Atrial Fibrillation				Arthritis/Joint Pain/Gout			
Blood Clot - DVT				Barrett's Esophagus/Esophageal Stricture			
Congestive Heart Failure				Gastrointestinal Ulcers			
Coronary Artery Disease				Glaucoma			
Deep Vein Thrombosis				Dialysis			
Diabetes (Insulin Dependent)				Obstructive Sleep Apnea/CPAP			
Emphysema				ESRD			
Heart Attack				Varicose Veins			
Heart Valve Disorder				Endocarditis (Infection of the Heart)			
Heparin Allergy				Diabetes Type II			
High Blood Pressure/Hypertension				Diabetic Kidney Problems			
High Cholesterol				Thyroid Disorder			
Lupus				Blood Thinner/Anticoagulation Use			
Nickel / Metal Allergy				Radiation Therapy			
Peripheral Vascular Disease/Claudication				Cancer/Tumors			
Pulmonary Embolism				Steroid Use (Prednisone)			
Seizure				Renal Diseases			
Stroke				Urinary Strictures			
TIA (Transient Ischemic Attack)				Tuberculosis			
Depression/Anxiety							

SURGICAL HISTORY: ☐ **YES** ☐ **NO** **If yes, please see below**

Type of Surgery	Date	Hospital
Heart Surgery		
Angioplasty		
Coronary Stent		
Aortic Aneurysm Repair		
CABG		
Cardiac Catheterization		
Carotid Endarterectomy		
Permanent Pacemaker/Auto Implantable Cardioverter Defibrillator		
Surgery for Cancer		
Lung Surgery		
Gastric Surgery		
Tonsillectomy		
Appendectomy		
Gallbladder Removal		
Bypass (Extremities)		
Amputation		
Vein Stripping		
Breast Implants, Reduction		
Breast Reconstruction (eg TRAM Flap)		
Dental Surgery/Dental Implants		
Other Surgery		
Other Hospitalization (other than surgery)		

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

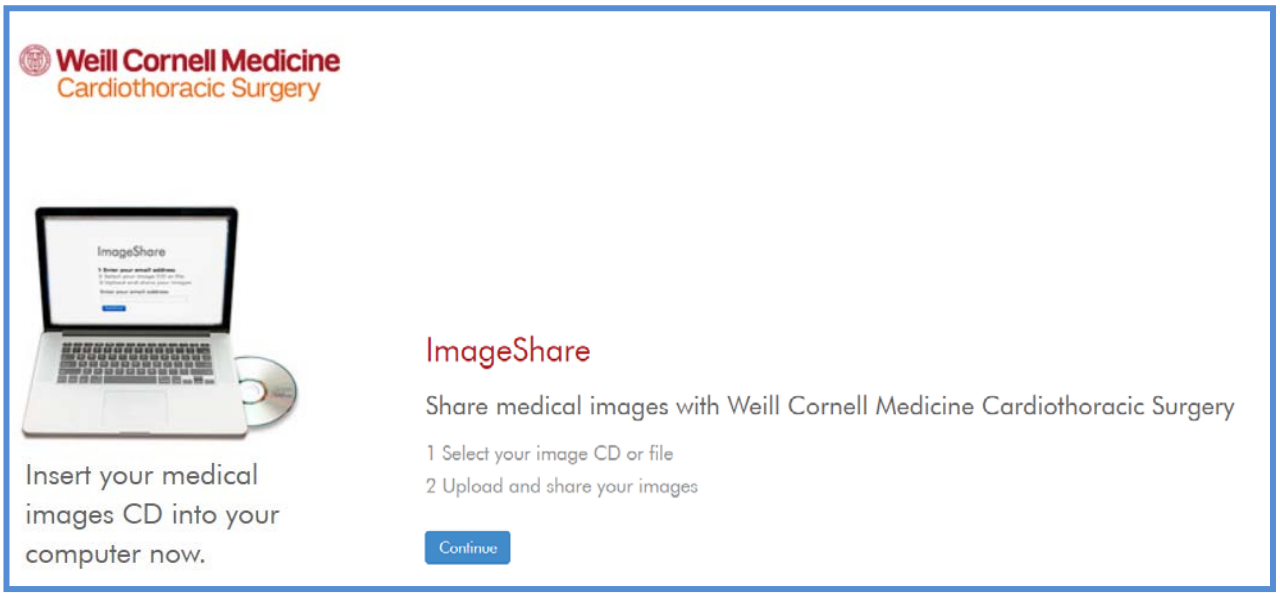
Name of Drug	Allergic Reaction

Notes

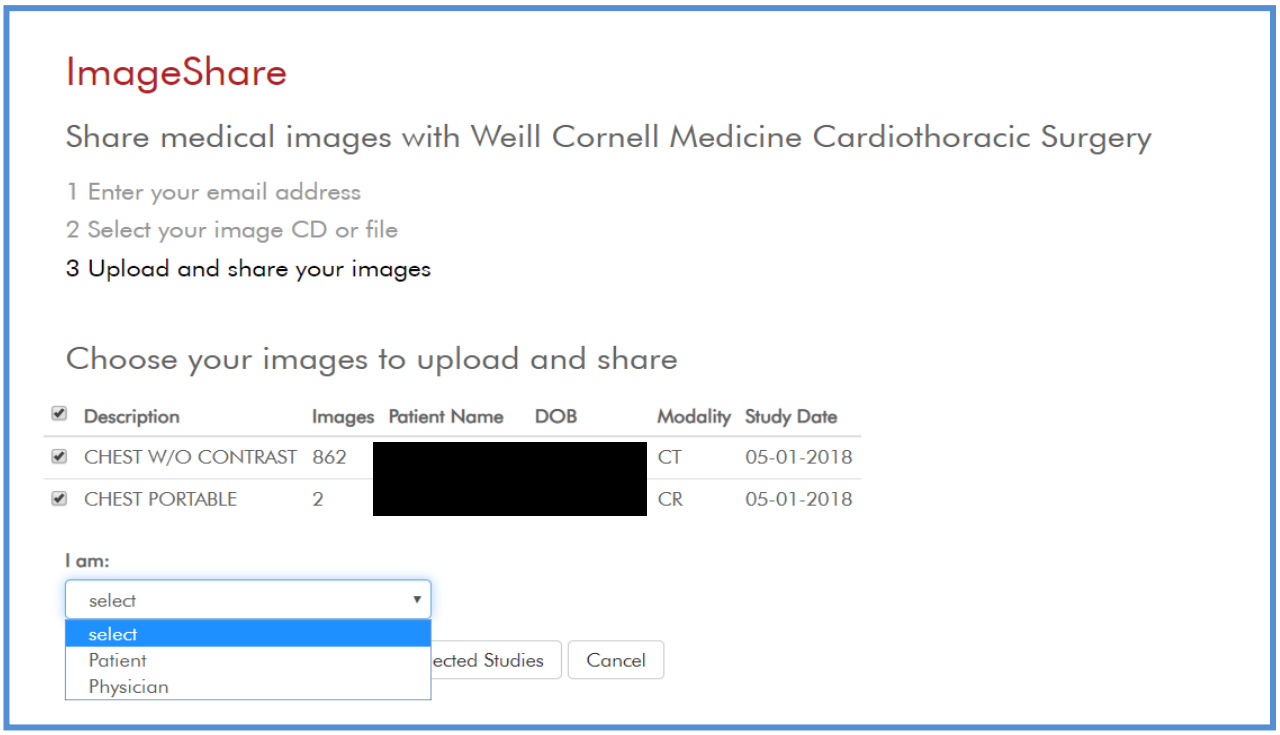
Ambra Upload Guide

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.

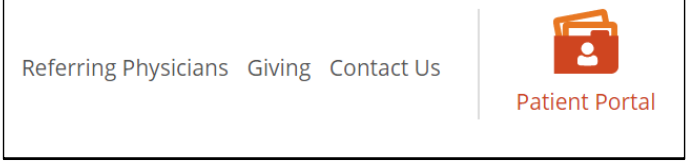
How to sign up Weill Cornell CONNECT patient portal:

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

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

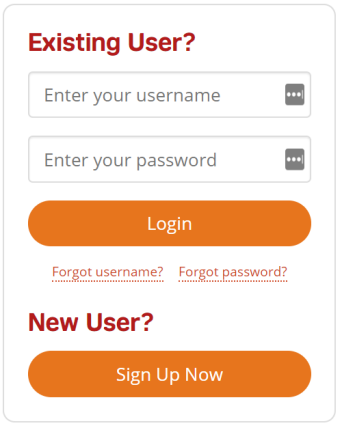
Go to: https://weillcornell.org/

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



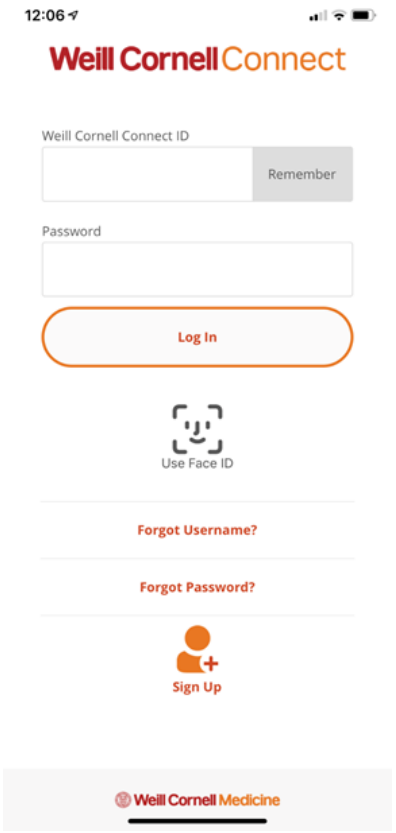
If you have an account please enter your username and password

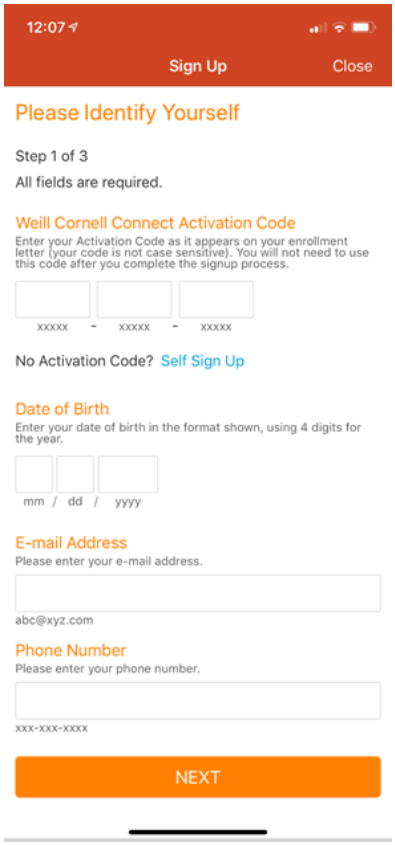
For New Users,
Click on Sign Up Now



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