Weill Cornell Medicine | NewYork-Presbyterian
Cardiothoracic 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 if appropriate. **PLEASE PRINT CLEARLY**

Date of Visit: _____

Patient Information:

Name:	Date of Birth:
Cell Phone:	Preferred Email:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner		
Spouse/Significant Other:	Patient's Occupation	Patient's Language Preference

Referral information:

How were you referred to us?	☐ WEBSITE ☐ HEALTH PLAN DIRECTORY ☐ FAMILY/FRIEND ☐ PHYSICIAN ☐ INTERNET ☐ PHYSICIAN REFERRAL SERVICE ☐ CORNELL WEBSITE ☐ INTERNATIONAL OFFICE ☐ CENTER FOR PERFORMING ARTS ☐ BROCHURE ☐ OTHER Please Specify: _____

Referring Physician:	Phone	Fax:
Address:		
Primary Care Physician	Phone	Fax:
Address:		
Pulmonologist	Phone	Fax:
Address:		
Gastroenterologist	Phone	Fax:
Address:		
Cardiologist	Phone	Fax:
Address:		

Other Doctors You Want Your Records To Be Sent To:

Health Information:

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

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

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

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	Cigarettes/Cigars/Pipe?	How many packs a day?	How many years?
Did you smoke? ☐ Yes ☐ No	Quit? ☐ Yes ☐ No	If yes, when did you quit?	
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 circle, if any of the following apply*

Constitutional	❑ Fatigue	❑ Insomnia	❑ Weight Change	❑ Fever	❑ Chills
Eyes	❑ Vision Changes	❑ Pain	❑ Floaters		
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 when laying		
Respiratory #1	❑ Shortness of Breath during activity		❑ Sputum	❑ Blood in Sputum	
Respiratory #2	❑ 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	❑ Urethral Discharge	❑ Nocturia	
Integumentary	❑ Rashes	❑ Skin Ulcers	❑ Alopecia	❑ Skin Changes	
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			
Hematology/ Lymphatic	❑ Swelling or enlarged lymph nodes		❑ 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.

Patient Signature: Name of person completing form (if not patient): Signature: Today's Date	Physician Signature: Today's Date: