Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

NEW PATIENT QUESTIONNAIRE CORNELL WOMEN'S HEART PROGRAM

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 <u>cardiologist</u> today? Please be as specific as possible (e.g., symptoms or tests.)

_____

Do you currently smoke? Yes:☐ No:☐ Did you ever smoke? Yes:☐ No:☐
If yes to any question, please indicate packs 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 <u>drinks per week</u> for each type.)

_____

Are you: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other:_____
Do you currently work? Yes:☐ No:☐ Occupation:_____

Has your menstruation stopped? Yes:☐ (age) No:☐
If yes, have you ever taken hormone replacement therapy for menopause? Yes:☐ No:☐
Have you had a hysterectomy? Yes:☐ No:☐
Have you had removal of both your ovaries? Yes:☐ (age) No:☐
Have you been pregnant? Yes:☐ No:☐
If yes, number of births? _____ Age at each pregnancy ____
If yes, did you have complications of pregnancy? Please circle if applies: gestational hypertension, gestational diabetes, pre-eclampsia, eclampsia

PAST CARDIAC MEDICAL HISTORY:

NEW PATIENT QUESTIONNAIRE CORNELL WOMEN'S HEART PROGRAM

Do **you** personally have a history of:	YES	NO	**DETAILS (e.g., dates, hospitals, treating physicians)**
Known coronary artery disease?			
- heart attack(s) requiring hospitalization			
- coronary artery stenting			
- coronary artery dissection			
- coronary artery bypass surgery			
Heart rhythm disorders?			
- pacemaker or defibrillator (ICD)?			
- atrial fibrillation or atrial flutter?			
- other arrhythmias?			
- cardioversion?			
- ablation procedure?			
Heart failure?			
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)?			
Other Medical History			
Thyroid disorder?			
Asthma/Emphysema/COPD?			
Stomach/peptic ulcers?			
Gastrointestinal bleeding?			
Heartburn/Reflux (GERD)?			
Cancer/Leukemia/Myeloma? What type?			
Did you receive radiation therapy?			
Did you receive chemotherapy? Type?			
History of a blood clot (DVT/PE)?			
Rheumatoid arthritis or Lupus?			
Polycystic ovarian syndrome (PCOS)?			
PAST CARDIAC SURGICAL HISTORY:			
Heart valve repair/replacement?			
Carotid artery surgery (endarterectomy)?			
Aortic aneurysm repair?			
Peripheral artery bypass surgery/stenting?			
Congenital heart disease repair? What type?			
OTHER NON CARDIAC SURGERY? What type?			
OTHER MEDICAL CONDITIONS?			

NEW PATIENT QUESTIONNAIRE CORNELL WOMEN'S HEART PROGRAM

Please indicate your family members' medical history as below:

	First Name	Alive? (Y/N)	Age	No History	Coronary Artery Disease (Heart attack, bypass surgery, stent)	Carotid Disease	Hyper-lipidemia?	Hyper-tension?	Stroke?
Father									
Mother									
Brother(s)									
Sister(s)									
Son(s)									
Daughter(s)									
Other(s)									

For any family member you have indicated "yes" for coronary artery disease, please list the specific details below (age at onset of the disease). If any family member died ***suddenly*** please indicate the age at death and the cause.

Family member Age at onset 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:_____

NEW PATIENT QUESTIONNAIRE CORNELL WOMEN'S HEART PROGRAM

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: _____

_____

_____

_____

_____

_____

_____

_____

NEW PATIENT QUESTIONNAIRE CORNELL WOMEN'S HEART PROGRAM

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/Eliquis/Pradaxai/Xarelto?		
ALLERGIC/IMMUNOLOGIC		
Diffuse itching?		
Anaphylaxis?		
Swelling of the throat?		
PSYCHIATRIC		
Depressed mood?		
Inability to enjoy anything?		
Anxiety?		
Suicidal thoughts?		
Hallucinations?		