



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 cardiologist 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 drinks per week 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



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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?

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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
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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:_____



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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
<i>Example: metoprolol</i>	<i>25 mg</i>	<i>Once daily</i>	<i>2005</i>

Do you take any non-prescription medications?

Yes: _____

No: _____

If yes, please list below: _____



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REVIEW OF SYSTEMS: Please indicate **IF YOU ARE CURRENTLY EXPERIENCING** any of the following signs and/or symptoms:

YES NO

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?

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?