Cardiology Wellness Center: New Patient Hal M. Roseman, MD, MPH, FACC, FACP

Name:	**Age:**	**Birth date:**
	Sex:	**Social Security Number:**
Family Doctor:		**Date:**
Email Address:		

I. Why are you seeing the cardiologist today?
LIST and DESCRIBE any symptoms, problems, or concerns. Indicate the date you first noticed these problems. DESCRIBE what you want or expect from today's visit?

Please list your five major health concerns (in order of importance to you):

1 _____
2 _____
3 _____
4 _____
5 _____

II. Past Medical History:

Have you ever ☐ been hospitalized, ☐ suffered any injuries, or ☐ undergone any surgeries? ☐ Yes, ☐ No. If so, please DESCRIBE with dates and circumstances of the events.

Are you aware of any ALLERGIES, either to any drugs, medications, food, latex, tape etc.

List all Medications, Nutritional or Herbal Supplements, Vitamins/Minerals you are now taking.
[Please bring in all of your medications and supplements]

In the last ten years, have you been *diagnosed* with any new medical problems? ☐ Yes, ☐ No.
If so, please Describe?

In the last ten years, have you been *tested* for any new medical problems? ☐ Yes, ☐ No.
If so, please Describe?

	When last evaluated?	Do you know the results?
☐ Hyperlipidemia or high cholesterol		
☐ High Blood Pressure		
☐ Diabetes or high blood sugar		
☐ Heart Conditions		
☐ Other Conditions		

III. Medical symptom list: Have you ever experienced any of the following problems? Check, only, if yes:

☐	Vision problems	☐	Frequent Heartburn	☐	Poor control of urination
☐	Cataracts / Glaucoma	☐	Reflux esophageal symptoms	☐	Prostate problems
☐	Prior head or neck injury	☐	Ulcers: esophagus, peptic, gastric	☐	Arthritis/ Joint and Muscle Aches
☐	Recurrent Headaches	☐	Gallbladder problems	☐	Gout
☐	Sinus allergy / Hay fever	☐	Hepatitis / Jaundice	☐	Swelling of ankle, feet, or legs
☐	Dizziness and/or Vertigo	☐	Diverticulitis; other colon problems	☐	Fainting or passing out
☐	Hearing difficulty	☐	Diarrhea or Constipation	☐	Black out spells
☐	Frequent sore throat, flu, or colds	☐	Recurrent back or leg pain	☐	Cancer/ Tumors
☐	Thyroid problems	☐	Blood clots	☐	Insomnia
☐	Asthma	☐	Anemia	☐	Fatigue or lack of energy
☐	Bronchitis	☐	Bleeding abnormality	☐	Anxiety/ Panic Attacks
☐	Emphysema	☐	Bladder / kidney problems	☐	Depression
		☐	Appetite Change / Anorexia	☐	Unusual weight loss or gain

Explain any items you checked: How long you have had any of these symptoms? Have you ever been evaluated for these symptoms?

How would you rate your physical conditioning and ability to exercise: ☐Excellent condition ☐ Good Condition ☐Fair Condition ☐Poor Condition? How far can you walk before getting short of breath or experiencing fatigue? _____ ☐Feet, ☐Blocks, or ☐Mile(s)? How many flights of stairs (assuming 10 steps per flight) can you walk before getting short of breath? _____ or before stopping? _____

Are you experiencing any of the following symptoms?

1	Shortness of breath	☐Yes	☐No
2	Swelling of your legs	☐Yes	☐No
3	Dizziness	☐Yes	☐No
4	Palpitations	☐Yes	☐No
5	Chest discomfort, pressure	☐Yes	☐No
6	Leg pain	☐Yes	☐No

If YES for any of the above symptoms, please explain:

Shortness of Breath (Dyspnea):

Do you have shortness of breath ☐ with exertion or ☐ with rest?
Have you noticed wheezing, when you engage in exertional activities? ☐Yes or ☐No?
Has your sleep been disturbed or have you ever been awakened by shortness of breath? ☐Yes or ☐No? If so, how many hours after falling asleep are you generally awakened with shortness of breath? _____ ?
Do you have: ☐ frequent respiratory infections or colds, ☐ seasonal allergies and sneezing, ☐ frequent sputum production, ☐ hacking cough, or ☐ wheezing?
Is your shortness of breath associated with swelling of your legs? ☐Yes or ☐No?

Swelling of your legs (Edema):

Is your swelling worse when you stand on your legs for a long time? ☐Yes or ☐ No?
Does your swelling in your legs go down in the morning? ☐Yes or ☐No?

Dizziness:

Does your dizziness occur, when you ☐ are lying still, ☐ get up quickly from a sitting or lying position, or ☐ turning your neck or upper torso or look upward?
Is your dizziness associated with ☐ palpitations or ☐ black-out spells / loss of consciousness?

Palpitations:

Describe the sensation: ☐ pounding, ☐ fast beating, ☐ skip beats, ☐ irregular beating, ☐ other: _____.
Are your symptoms associated with ☐ shortness of breath, ☐ chest pain or pressure, ☐ lightheadedness or dizziness, or ☐ black-out spells or syncope?

Chest Pain:

- Do you have ☐ chest pain or ☐ chest discomfort? Please describe the character of the discomfort? ☐ burning, ☐ aching, ☐ sharp, knife-like, ☐ pressure, ☐ indigestion-like, ☐ squeezing, ☐ other: _____?
- Does your chest pain or discomfort occur: ☐ randomly during the day (no rhyme or reason), or predominantly ☐ when while at work, ☐ while at home or during off-work hours, ☐ during sleep? Is the symptom associated with ☐ specific activities, ☐ exertional activities, ☐ sexual activities, or ☐ meals?
- Does the discomfort improve with ☐ lying, ☐ upright position, ☐ antacids, or ☐ rest?
- How long have you had this chest pain? _____ years, _____ weeks, or _____ days?
- Is the discomfort associated with ☐ belching, ☐ flatus or gas, ☐ nausea, ☐ vomiting, ☐ sweating or perspiration, ☐ black-out spells or near-syncope, or ☐ palpitations or irregular/fast heart beating?
- How long typically does this symptom last? ☐ less than 5 minutes, ☐ 5-30 minutes, or ☐ hours?
- Where is the pain or discomfort located? ☐ Chest: ☐ middle, ☐ left, or ☐ right; ☐ Sternum (or breast bone): ☐ right, ☐ left; ☐ Shoulder: ☐ right, ☐ left?
- Does the pain radiate or is referred to another part of the body? ☐ Yes or ☐ No? If so, where? ☐ Arm: ☐ left, ☐ right, ☐ both; ☐ Neck: ☐ left, ☐ right, ☐ base; ☐ Back: ☐ upper, ☐ middle (between shoulders)? How does this radiating discomfort feel? ☐ numbness, ☐ achiness, ☐ pins and needles?

Leg Pain:

When does the pain occur? ☐ at rest, ☐ when walking only, ☐ when walking at a slow pace, or ☐ when walking at a rapid pace?
Do you have pain in either leg when walking? ☐Yes or ☐No?
Does the pain stop with rest? ☐Yes or ☐No? What part of the leg hurts: ☐ calf or calves or ☐ hips or thighs?
How long after resting does the pain disappear? ☐ within 10 minutes or ☐ longer?

IV. Social History and Habits:

Marital Status: Are you ☐Married, ☐Separated, ☐Divorced, ☐Widowed, ☐Single, ☐Living with partner?
With whom do you share your home? ☐Spouse or partner, ☐Children, or ☐Other: _____
How many children: _____? Ages: _____ _____

Highest education: ☐ high school or less, ☐ college, ☐ graduate or professional school?
What type of work do you do? _____ Work hours per week? _____
If retired, what type of work did you do for a living most of your life? _____

Do you currently use any tobacco products? ☐Yes, ☐No, ☐ Never did.
If so, ☐ cigarettes, ☐ cigars, ☐ chewing tobacco or snuff?
Have you ever smoked cigarettes? ☐Yes (_____ packs a day for _____ years), ☐ Never did
Do you currently smoke cigarettes? ☐Yes (_____ packs a day); ☐ No (When did you quit? _____ years ago)

Do you drink regularly any of the following?

1. Coffee: ☐No ☐Yes _____ cups a day
2. Tea: ☐No ☐Yes _____ cups or _____ glasses per day
3. Soda/cokes: ☐No ☐Yes _____ servings a day
4. Beer: ☐No ☐Yes _____ cans/bottles (☐8, ☐12, ☐16 oz) a week
5. Wine: ☐No ☐Yes _____ glasses a week (3 ounce glasses)
6. Liquors: ☐No ☐Yes _____ numbers of drinks (1.5 ounce per drink) a week

Have you ever drunk alcohol without eating for a day or more? ☐No ☐Yes?
Has anyone suggested that you seek counseling for alcohol treatment? ☐No ☐Yes?

Diet:
Do you drink milk, eat cheese or yogurt, or take calcium supplements on a regular basis? ☐No ☐Yes Details:
_____
What is your typical *daily* consumption of fruits, vegetables, or coarse grains? ☐0-1, ☐2-3, ☐4-5 portions.
What is your typical *weekly* consumption of nuts? ☐0-1, ☐2-3, ☐4-5 portions.
What is your typical *weekly* consumption of legumes (for example, beans)? ☐0-1, ☐2-3, ☐4-5 portions.

Do you take any routine vitamin, minerals, or other type of supplements? ☐No ☐Yes, Details:
_____
Do you have any problems with eating, digestion, or elimination? ☐No ☐Yes, Details:
_____

Miscellaneous:
Do you wear seatbelts when you drive: ☐always, ☐sometimes, or ☐never?
Do you have a gun at home? ☐No ☐Yes

Exercise History:

Do you perform routine exercise? ☐No ☐Yes?
If so, how often? _____ times per week. How long are your exercise sessions? _____ minutes.
What kind of exercises? ☐ bicycling, ☐running, ☐walking, ☐ calisthenics and stretching, ☐ water aerobics, ☐ weight lifting and body toning, ☐dancing, ☐ golf, ☐ jog, ☐ other: _____.

V. Psychosocial Inventory:

Do you perceive yourself as being overweight? ☐Yes ☐No?
How heavy? ☐ Extremely, ☐ Moderately, or ☐ Minimally?

How is your relationship with spouse and partner? (1=major problems, 5=wonderful) 1 2 3 4 5 _____
How is your relationship with children? (1=major problems, 5=wonderful) 1 2 3 4 5 _____

Would you describe your relationship with your mother (if deceased, when she was alive) as: ☐ very close, ☐ warm and friendly, ☐ tolerant, or ☐ strained or cold?

Would you describe your relationship with your father (if deceased, when he was alive) as: ☐ very close, ☐ warm and friendly, ☐ tolerant, or ☐ strained or cold?

Do you participate regularly in organized social groups (e.g., clubs, church, synagogue, other houses of worship) and/or civic activities? ☐Yes ☐No?

Do you draw strength and comfort from your religious or spiritual faith (whatever your religious or spiritual faith might be)? ☐Yes ☐No?

If you become ill, is there a friend of family member who you would feel comfortable in driving you to the hospital or would you take a taxi or ambulance? ☐ friend, ☐ family, ☐ taxi, or ☐ ambulance.

If you were broke, is there a friend who would loan you money? ☐Yes ☐No? If you were sick, is there a friend or family member who would take care of your children, if you have any, until your health recovered? ☐Yes ☐No?

Do you feel:
Isolated or lonely? ☐No ☐Yes? Explain: _____
Miserable and sad? ☐No ☐Yes? Explain: _____
More irritable or grumpy than usual? ☐No ☐Yes Explain: _____

Do you ever have or feel like having weeping spells? ☐No ☐Yes? Explain: _____

Do you feel that you worry *excessively* about things? ☐No ☐Yes? Explain: _____

Do you experience sensations of shortness of breath, palpitations or shaking while at rest? ☐Yes ☐No?

Do you have a fear of losing control of yourself or of "going crazy"? ☐Yes ☐No?

Do you avoid social situations because of feelings of fear or anxiety? ☐Yes ☐No?

Do you have specific fears of certain objects or things (for example, darkness or closed spaces)? ☐No ☐Yes? Explain: _____

Does the idea of leaving home frighten you or make you anxious or upset? ☐Yes ☐No?

Do you have recurrent thoughts or images in your head that refuse to go away? ☐Yes ☐No?

Do you feel compelled to perform certain behaviors repeatedly (for example, checking that you locked the doors or turning off the gas)? ☐No ☐Yes? Explain: _____

Do you persistently relive an upsetting event from the past? ☐Yes ☐No?

Do you find it difficult to do the things you used to do? ☐No ☐Yes? Explain: _____

Do you ever get frightened or panicky feeling for apparently no reason at all? ☐No ☐Yes? Explain: _____

Do you still enjoy the things that you used to in the past? ☐No ☐Yes Explain: _____

Are you restless and can't keep still? ☐No ☐Yes Explain: _____

Do you fall asleep easily and remain asleep without the need for sleeping pills? ☐Yes ☐No

Do you feel that you have lost interest in things, hobbies, or activities that pleased you in the past? ☐No ☐Yes Explain: _____

Do you get tired for no obvious reason? ☐No ☐Yes Explain: _____

Have persons close to you noticed that your behaviors have changed? ☐No ☐Yes Explain:_____

VI. Family History:

Has anyone in your family died or had any of the following medical conditions:
☐No, ☐Yes, please explain: _____

Stroke or Mini-strokes (Transient Ischemic Attacks):_____
Heart Disease or Attack: _____
Cancer: _____
Diabetes: _____
Peripheral vascular disease: _____
High Cholesterol: _____

	If Living:		**If Dead:**		
	Age	Any Health Problems?	Age at Death	Cause of Death	Health Problems during Life?
Father					
Mother					
Brother(s)					
Brother(s)					
Sister(s)					
Sister(s)					
Husband/Wife/Partner					
Son(s)/daughter(s)					
Son(s)/daughter(s)					
Grandparents					