Cardiology Associates
New Patient Evaluation

(SHADED AREA FOR OFFICE USE ONLY)

Patient: ______________________ Ht: ________ Wt: ________ Temp: _________
Date: __________ Chart: ____________ BP: ________ / ________ Pulse: _________
Referring Physician: ____________________ Allergies: ______________________________
____

History: CHIEF COMPLAINT & HISTORY of PRESENT ILLNESS:
____
____
____
____

Medications: ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Previous Surgeries: ____
____

MEDICAL HISTORY:

- Patient medical history

	(Check One)		If yes, please give explanation
Diabetes	☐ NO	☐ YES	____________________
Hypertension	☐ NO	☐ YES	____________________
Cancer	☐ NO	☐ YES	____________________
Stroke	☐ NO	☐ YES	____________________
Heart trouble	☐ NO	☐ YES	____________________
Arthritis / gout	☐ NO	☐ YES	____________________
Convulsions	☐ NO	☐ YES	____________________
Bleeding tendency	☐ NO	☐ YES	____________________
Acute infections	☐ NO	☐ YES	____________________
Hereditary defects	☐ NO	☐ YES	____________________
High Cholesterol	☐ NO	☐ YES	____________________
Lung problems	☐ NO	☐ YES	____________________

- Patient social history

Date of Birth: __________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Use of tobacco: ☐ Never ☐ Previously, but quit Current packs/day _____
Use of drugs: ☐ Never Type/Frequency ______________________________

- Family medical history – immediate family (living or deceased)

	(Check One)		If yes, please give explanation
Diabetes...........................	☐ NO	☐ YES	____________________
Hypertension	☐ NO	☐ YES	____________________
Stroke..............................	☐ NO	☐ YES	____________________
Cholesterol.......................	☐ NO	☐ YES	____________________
Alcoholism	☐ NO	☐ YES	____________________
Heart problems.................	☐ NO	☐ YES	____________________
Cancer.............................	☐ NO	☐ YES	____________________

OTHER: ____

Patient Name: ___________________________________

SYSTEM REVIEW

- CONSTITUTIONAL SYMPTOMS (*Check One*)
  - Good general health lately ☐ No ☐ Yes
  - Recent weight change ☐ No ☐ Yes
  - Fever ☐ No ☐ Yes
  - Tired ☐ No ☐ Yes
  - Headaches ☐ No ☐ Yes

- CARDIOVASCULAR (*Check One*)
  - Heart trouble ☐ No ☐ Yes
  - Chest pain or angina pectoris ☐ No ☐ Yes
  - Palpitation ☐ No ☐ Yes
  - Shortness of breath ☐ No ☐ Yes
  - Swelling of feet, ankles or hands ☐ No ☐ Yes
  - Muscle discomfort while walking ☐ No ☐ Yes

- NEUROLOGICAL (*Check One*)
  - Light headed or dizzy ☐ No ☐ Yes
  - Numbness or tingling sensations ☐ No ☐ Yes
  - Paralysis ☐ No ☐ Yes
  - Head injury ☐ No ☐ Yes

- RESPIRATORY (*Check One*)
  - Chronic or frequent coughs ☐ No ☐ Yes
  - Spitting up blood ☐ No ☐ Yes
  - Asthma or wheezing ☐ No ☐ Yes

- GASTROINTESTINAL (*Check One*)
  - Loss of appetite ☐ No ☐ Yes
  - Nausea or vomiting ☐ No ☐ Yes
  - Rectal bleeding or blood in stool ☐ No ☐ Yes
  - Abdominal pain or heartburn ☐ No ☐ Yes
  - Peptic Ulcer ☐ No ☐ Yes
  - Pancreatitis ☐ No ☐ Yes
  - Liver Disease ☐ No ☐ Yes
  - Diverticulitis ☐ No ☐ Yes
  - Gallbladder Disease ☐ No ☐ Yes

- MUSCULOSKELETAL (*Check One*)
  - Joint stiffness, swelling or pain ☐ No ☐ Yes
  - Weakness of muscles or joints ☐ No ☐ Yes
  - Muscle pain or cramps ☐ No ☐ Yes
  - Back pain ☐ No ☐ Yes
  - Gout ☐ No ☐ Yes

- INTEGUMENTARY (skin) (*Check One*)
  - Rash or itching ☐ No ☐ Yes
  - Change in skin color ☐ No ☐ Yes
  - Varicose veins ☐ No ☐ Yes

- GENITOURINARY (*Check One*)
  - Female
    - Frequent bladder infections ☐ No ☐ Yes
    - Post menopausal ☐ No ☐ Yes
  - Male
    - Decrease in urinary force/flow ☐ No ☐ Yes
    - Prostate Disease ☐ No ☐ Yes

- ENDOCRINE (*Check One*)
  - Glandular or hormone problem ☐ No ☐ Yes
  - Thyroid disease ☐ No ☐ Yes
  - Excessive thirst or urination ☐ No ☐ Yes
  - Heat or cold intolerance ☐ No ☐ Yes

- HEMOTOLOGIC/LYMPHATIC (*Check One*)
  - Slow to heal after cuts ☐ No ☐ Yes
  - Anemia ☐ No ☐ Yes

- HEAD AND NECK (*Check One*)
  - Trouble with vision ☐ No ☐ Yes
  - Decreased hearing ☐ No ☐ Yes
  - Ringing in ears ☐ No ☐ Yes
  - Hoarseness ☐ No ☐ Yes

- OTHER: ___________________________________

  ____

  ____

(SHADED AREA FOR OFFICE USE ONLY)

Physician Signature: ___________________________________ Date: ___________________________