Cardio Vascular Institute of AZ

New Patient History Form

Please fill out this form to the best of your ability. If you come to a question that you are unsure how to answer, skip it and discuss it with the Medical Assistant who examines you. The receptionists will not be able to assist you.

Please mark which physician you will be seeing: ❑ Dr. Akhtar ❑ Dr. Fatima ❑ Dr. Lipskind ❑ Dr. Haddad

Patient Name: ____________ First ____________ Middle ____________ Last ____ / ____ / ____ Date of scheduled visit

DOB: _______ / ______ / ________ **Age:** _________ **Ht:**______ **Wt:**______ **Gender:** ❑ Male ❑ Female

Name of Physician who referred you to us: ______________________________

Reason for Visit

What is the main reason for your visit today? (Describe in detail): ______________________________

Allergies

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list them on the lines below.

Are you allergic to any of the following? (please check all that apply) ❑ X-Ray Contrast Dye ❑ Iodine ❑ Shell Fish ❑ Latex ❑ Silk Tape ❑ Grass ❑ Pollens ❑ Dust ❑ Make-up ❑ Lactose

Do you have Hay Fever? ❑ Yes ❑ No If yes, is it: ❑ Continual or ❑ Seasonal

If you are allergic to anything else, please list them here: ______________________________

Current Prescription Medications

Are you currently taking any prescription medications? ❑ Yes ❑ No If yes, please list them below.

Please take your time with this section and write as legible as possible.

Current Medications	Dose (strength)	Schedule	How long have you taken?	Why are you taking?
example: *Atenolol*	*50mg*	*1pill, once a day*	*6months*	*high blood pressure*

Current Non-Prescription Medications or Supplements

You can also use this section if you did not have enough room to list all of your Prescription Medications

Are you currently taking any Non-Prescription Medications or Supplements? ❑ Yes ❑ No If yes, please list them below.

(example: multivitamins, fish oil, herbals, calcium, hay fever medications, glucosamine, etc…)

Current Medications	Dose (strength)	Schedule	How long have you taken?	Why are you taking?
example: Sudafed	60mg	as needed	6months	seasonal allergies

History of Present Illness

Do you, or have you had any Chest Discomfort? ❑ Yes ❑ No If yes, please check below all that apply.

The Chest Discomfort is best described as:

❑ Chest Pain ❑ Chest Pressure ❑ Chest Tightness ❑ Chest Heaviness

This Chest Discomfort is: ❑ Sharp **or** ❑ Dull

On a scale from 0 to 10 (0 is no discomfort and 10 is the worst), what number would you give this chest discomfort? _______

In regards to the above Chest Pain, Pressure or Heaviness, does it or is this discomfort: (check all that apply)

❑ occur in the middle of the chest only.
❑ radiate to the:
  ❑ neck ❑ jaw
  ❑ ears ❑ arms
❑ occurs while lying down.
❑ occur at rest.
❑ occur with moderate activity.
❑ occur with strenuous activity.
❑ associated with shortness of breath.
❑ associated with nausea, sweating.
❑ associated with fatigue, Dizziness.
❑ associated with fainting.
❑ associated with choking feeling.
❑ occur after eating food.
❑ occur at higher altitudes.
❑ occur when I'm emotionally upset.
❑ wake me up from sleep.
❑ worsen when I take a deep breath.

The intensity, frequency & duration of chest discomfort has increased in the past:_____ ❑ days ❑ weeks ❑ months ❑ years

Do you, or have you had any Shortness of Breath (SOB)? ❑ Yes ❑ No If yes, please check below all that apply.

❑ SOB along with chest pain.
❑ SOB along with nausea, sweating.
❑ SOB associated with fainting.
❑ SOB occurs at rest.
❑ SOB occurs with strenuous activity.
❑ SOB occurs with moderate activity.
❑ SOB occurs while lying down.
❑ SOB occurs after eating food.
❑ SOB occurs at higher altitude.
❑ SOB occurs with walking uphill.
❑ SOB occurs with lifting heavy objects.
❑ SOB occurs with emotional upset.
❑ SOB wakes me up from sleep.
❑ SOB associated with choking feeling.

The intensity, frequency & duration of SOB has increased in the past: ______ ❑ days ❑ weeks ❑ months ❑ years

Do you, or have you had any Dizziness? ❑ Yes ❑ No If yes, please check below all that apply.

❑ Dizziness with chest pain.
❑ Dizziness with fatigue.
❑ Dizziness with nausea, sweating.
❑ Dizziness associated with fainting.
❑ Dizziness occurs at rest.
❑ Dizziness occurs with strenuous activity.
❑ Dizziness occurs with moderate activity.
❑ Dizziness occurs while lying down.
❑ Dizziness occurs after eating food.
❑ Dizziness occurs with at higher altitude.
❑ Dizziness occurs with walking uphill.
❑ Dizziness occurs lifting heavy objects.
❑ Dizziness occurs with emotional upset.
❑ Dizziness wakes me up from sleep.
❑ Dizziness occurs with choking feeling.

The intensity, frequency & duration of Dizziness has increased in the past: ______ ❑ days ❑ weeks ❑ months ❑ years

History of Present Illness (continued)

Do you, or have you had any Palpitations? ❑ Yes ❑ No If yes, please check below all that apply.

(Palpitations are a feeling of rapid fluttering of the heart)

❑ Palpitations in the middle of your chest.
❑ Palpitations with chest pain.
❑ Palpitations with fatigue, Dizziness.
❑ Palpitations with nausea, sweating.
❑ Palpitations associated with fainting.
❑ Palpitations occur at rest.
❑ Palpitations occur with strenuous activity.
❑ Palpitations occur with moderate activity.
❑ Palpitations occur while lying down.
❑ Palpitations occur with at higher altitudes.
❑ Palpitations occurs while walking uphill.
❑ Palpitations occur lifting heavy objects.
❑ Palpitations occur with emotional upset.
❑ Palpitations wake me up from sleep.
❑ Palpitations occur with choking feeling.

The intensity, frequency & duration of palpitations have increased in the past: ______ ❑ days ❑ weeks ❑ months ❑ years

Do you, or have any swelling of the legs or feet? ❑ Yes ❑ No If yes, please check below all that apply.

❑ Swelling of the legs above the knee ❑ Swelling of the legs below the knees ❑ Swelling of the feet

Past Cardiovascular History

Have you ever had any of the following:			Date or Year	Complications/Problems
Exam by a Cardiologist?	❑ Yes	❑ No	___________	___________
Exercise Stress Test (treadmill)?	❑ Yes	❑ No	___________	___________
Echocardiogram?	❑ Yes	❑ No	___________	___________
Nuclear stress test?	❑ Yes	❑ No	___________	___________
Heart attack?	❑ Yes	❑ No	___________	___________
Heart Catheterization (Angiogram)?	❑ Yes	❑ No	___________	___________
Angioplasty or Stent in the heart?	❑ Yes	❑ No	___________	___________

Have you ever had any of the following:			Date or Year	Complications/Problems
Angiogram, Angioplasty or Stent elsewhere in your body?	❑ Yes	❑ No	___________	___________
Pacemaker implant?	❑ Yes	❑ No	___________	___________
Cardiac Defibrillator implant?	❑ Yes	❑ No	___________	___________
Heart failure or "fluid in the lungs"?	❑ Yes	❑ No	___________	___________
Swelling in the legs or feet?	❑ Yes	❑ No	___________	___________
Stroke?	❑ Yes	❑ No	___________	___________

Past Medical History

Do you have:						**How long have you had this condition?**
High blood pressure?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________
High cholesterol?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________
COPD?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________
Peptic Ulcer Disease?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________
Kidney Disease?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________
Acid Reflux Disease?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________
An over-weight problem?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________
Diabetes?	❑ Yes	❑ No	If yes, are you on medication for this?	❑ Yes	❑ No	___________

If you are on medications are they: ❑ Oral medications? ❑ Insulin injections?

A stressful life or lifestyle? ❑ Yes ❑ No If yes, please explain: ___________

Previous Operations/Procedures	Year	Doctor	Location	Complications

Past Medical History (continued)	
List any other past or present medical illnesses, chronic conditions	How long have you had this?

Social History

Do you exercise on a regular basis? ❑ Yes ❑ No If yes, describe ________________

Do you consume caffeine on a regular basis? ❑ Yes ❑ No

If yes, do you consume: ❑ Coffee ❑ Tea ❑ Colas ❑ Energy drinks

How often do you consume these drinks: ______ times per: ❑ day ❑ week ❑ month ❑ year

Do you or have you consume alcohol on a regular basis? ❑ Yes ❑ No If yes, describe ________________

If yes, do you consume: ❑ mixed drinks ❑ beer ❑ wine ❑ hard liquor

How often do you consume these drinks: ______ times per: ❑ day ❑ week ❑ month ❑ year

I am a recovering alcoholic and have not had a drink for the past: ______ ❑ days ❑ weeks ❑ months ❑ years

Do you now, or have you ever used tobacco products? ❑ Yes ❑ No

If yes, please fill out all that apply below. If no, do you live with someone who does smoke? ❑ Yes ❑ No

Cigarettes: # of packs per day: ________ # of years?_______ Are you still smoking cigarettes? ❑ Yes ❑ No

I quit ______ ❑ days ❑ weeks ❑ months ❑ years ago.

Chew: # of cans per week: ________ # of years?_______ Are you still chewing? ❑ Yes ❑ No

I quit ______ ❑ days ❑ weeks ❑ months ❑ years ago.

Cigars: # of cigars per day:_________ # of years?_______ Are you still smoking cigars? ❑ Yes ❑ No

I quit ______ ❑ days ❑ weeks ❑ months ❑ years ago.

Pipe: # of bowls per day:_________ # of years?_______ Are you still smoking a pipe? ❑ Yes ❑ No

I quit ______ ❑ days ❑ weeks ❑ months ❑ years ago.

Do you now, or have you ever consumed any street drugs? ❑ Yes ❑ No If yes, describe

Family History

Please check which blood relatives that have had the following: (check all that apply)

Heart Attack:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
Stroke:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
High Blood Pressure:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
High Cholesterol:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
Heart Failure:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
Arteriosclerosis:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
Aneurysms:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
Diabetes:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
Cancer:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister
Sudden death:	❑ Grandfather	❑ Grandmother	❑ Father	❑ Mother	❑ Brother	❑ Sister

Is your natural mother alive? ❑ Yes ❑ No

If yes, what is her age? ______ If no, how old was she when she died?

If she is alive, does she have any significant illnesses not listed above? (please list in the line below)

____

Is your natural father alive? ❑ Yes ❑ No

If yes, what is his age? ______ If no, how old was he when he died?

If he is alive, does he have any significant illnesses not listed above? (please list in the line below)

____

If you have any other information that would assist us in your care, please describe below.

I certify that the information filled out in this form is true and accurate.

Signature