NEW PATIENT FORM

Name: _____ NWFHG# _____

Marital Status: _____ Age: _____

Occupation: _____ Date: _____

Primary Care Physician: _____

Referring Physician: _____

Reason for Visit: _____

Have you had any of the following:

	Yes	No
Heart Attack (MI)		
Diabetes		
Hypertension		
High Cholesterol/ Triglycerides		
Congestive Heart Failure		
Blocked or Narrowed arteries in Neck		

	Yes	No
Rheumatic Fever		
Heart Valve Disease		
History of Heart Murmur		
Atrial Fibrillation or Flutter		
Supraventricular Tachycardia (SVT)		
Blocked or Narrowed arteries in Arm/Leg		

	Yes	No
Ventricular Tachycardia (VT)		
Cardiac Arrest		
Abdominal Aneurysm (AAA)		
Stroke / TIA		
Blood Clot in Leg (DVT)		
Blood Clot in Lung (PE)		

	Yes	No
Cancer		
Emphysema (COPD)/ Asthma		
Heart Valve Surgery		
Pacemaker Implant		
Stent Placed in Neck		
Liver Disease/ Cirrhosis		

	Yes	No
Thyroid Disease		
Kidney Failure/ Dialysis		
Coronary Artery Bypass (CABG)		
Defibrillator (ICD) Implant		
Stent Placed in Abdomen		
Seizure Disorder		

	Yes	No
Sleep Apnea		
Cardiac Catheterization		
Radiofrequency Ablation		
Stent Placed in Leg/ Arms		
Stomach Ulcer/ Bleeding		
Parkinson's Disease		

Please list any other medical or surgical conditions or procedure that you may have had: _____

Have you currently or in the recent past experienced any of these symptoms:

	Yes	No
Anorexia		
Fatigue		
Fever		
Night Sweats		
Bruising		
Rash		
Blurred Vision		
Double Vision		
Visual Loss		
Neck Pain		
Cough		
Coughing up Blood		

	Yes	No
Chest Pain		
Claudications		
Shortness of Breath on Exertion		
Edema		
Fainting/ Blacking Out		
Trouble Breathing while lying flat		
Palpitations		
Abdominal Pain		
Bloody Stool		
Constipation		
Diarrhea		
Difficulty Swallowing		

	Yes	No
Tarry Stools		
Nausea		
Vomiting		
(MALE) Blood in Urine		
Back Pain		
Calf Pain		
Muscle Weakness		
Difficulty Speaking		
Frequent Headaches		
Excessive Thirst		
Frequent Urination		
Blood Clots		
Excessive Bleeding		

Please list any other symptoms that you may be experiencing: _____

(Please fill out the back of the page also.)

Have any of your blood relatives had the following:

	Yes	No
Heart Attack (MI)		
Coronary Artery Disease (CAD)		

	Yes	No
Heart Bypass Surgery/ Stents/ Angioplasty		
Sudden Unexpected Death		

If answered "YES," please state whom: _____

Personal History: (Please Circle)

Do you Smoke	YES	NEVER	If QUIT What Year did you Quit?
Do you Drink Alcohol	YES	NO	Occasionally Heavy
Do you Use Illicit Drugs	YES	NEVER	
Do you Exercise Regularly	LIGHT	MODERATE	HEAVY INACTIVE
Do you Drink Caffeine	YES	NEVER	If "YES," How many Servings daily: 1 2 3 4 5 6 7 8 9 10

Allergies: _____

****Please bring an UPDATED list of your current daily medications or bring medication bottles to the appointment.**