Medical Record Number

Patient Name

Addressograph Stamp - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS • CARDIOVASCULAR •
NEW PATIENT QUESTIONNAIRE

CARDIOLOGY CLINIC PATIENT QUESTIONNAIRE

Name (Last, First)	Birthdate	Age	Sex ☐ M ☐ F

Appointment Date	Cardiology Clinic Physician

Did another physician refer you? ☐ **Yes** ☐ **No**

If yes, please complete the following so that the Cardiology Clinic physician can send a report to your referring physician.

Referring MD Name _____

Street Address _____

City, State, Zip Code _____

Phone ( ) _____ Fax ( ) _____

If you have a primary care physician other than your referring physician, please complete the following so that the Cardiology Clinic physician can send a report to your referring physician.

Primary Care MD Name _____

Street Address _____

City, State, Zip Code _____

Phone ( ) _____ Fax ( ) _____

Would you like the information from today's Cardiology Clinic appointment sent to any physician other than those listed above? ☐ **Yes** ☐ **No**

MD Name _____

Street Address _____

City, State, Zip Code _____

Phone ( ) _____ Fax ( ) _____

What is the reason for this appointment today in the Cardiology Clinic?

_____

_____

_____

_____

_____

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REVIEW OF SYSTEMS:

Have you experienced any of the following symptoms? Please check yes, or no. If yes, please give an explanation.
Physician: Please check box if WNL or record abnormalities. Leave blank if not reviewed.

SYSTEM	Patient: Check Response	Physician/Patient Comments
ALLERGY/IMMUNOLOGY		❑ WNL
Low resistance to infection	❑ YES ❑ NO	
Environmental allergies	❑ YES ❑ NO	
CARDIOVASCULAR		❑ WNL
Chest pain or angina	❑ YES ❑ NO	
Irregular heart rhythm	❑ YES ❑ NO	
Swelling of the feet, ankles, hands	❑ YES ❑ NO	
CONSTITUTIONAL		❑ WNL
Good general health lately	❑ YES ❑ NO	
Recent weight changes	❑ YES ❑ NO	
Extreme fatigue	❑ YES ❑ NO	
Frequent nausea, vomiting	❑ YES ❑ NO	
Difficulty sleeping	❑ YES ❑ NO	
EARS, NOSE, MOUTH, THROAT		❑ WNL
Change in hearing	❑ YES ❑ NO	
Ringing in the ears	❑ YES ❑ NO	
Recent nose bleeds	❑ YES ❑ NO	
Chronic sinus problems	❑ YES ❑ NO	
Voice changes	❑ YES ❑ NO	
EYES		❑ WNL
Wear glasses, contact lenses	❑ YES ❑ NO	
Change in vision	❑ YES ❑ NO	
Glaucoma	❑ YES ❑ NO	
ENDOCRINE		❑ WNL
Heat or cold intolerance	❑ YES ❑ NO	
Excess thirst or urination	❑ YES ❑ NO	
GASTROINTESTINAL		❑ WNL
Change in appetite	❑ YES ❑ NO	
Severe heart burn	❑ YES ❑ NO	
Vomiting blood	❑ YES ❑ NO	
Frequent diarrhea	❑ YES ❑ NO	
Constipation	❑ YES ❑ NO	
Black or bloody stools	❑ YES ❑ NO	
Abdominal pain	❑ YES ❑ NO	
GENITOURINARY		❑ WNL
Blood in urine	❑ YES ❑ NO	
Burning with urination	❑ YES ❑ NO	
Difficult/frequent urination	❑ YES ❑ NO	
Lack of bladder control	❑ YES ❑ NO	

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SYSTEM	Patient: Check Response	Physician/Patient Comments
GENITOURINARY (con't.)		❑ WNL
Sexually transmitted disease	❑ YES ❑ NO	
Change in sexual function	❑ YES ❑ NO	
HEMATOLOGY/LYMPHATIC		❑ WNL
Easy bruising	❑ YES ❑ NO	
Frequent bleeding	❑ YES ❑ NO	
Enlarged lymph nodes	❑ YES ❑ NO	
INTEGUMENTARY SKIN & BREASTS		❑ WNL
Unusual or prolonged rashes	❑ YES ❑ NO	
Breast pain or lump	❑ YES ❑ NO	
Change in hair or nails	❑ YES ❑ NO	
MUSCULOSKELETAL		❑ WNL
Joint/muscle stiffness or pain	❑ YES ❑ NO	
Weakness of muscles or joints	❑ YES ❑ NO	
Back pain	❑ YES ❑ NO	
Difficulty walking	❑ YES ❑ NO	
NEUROLOGICAL		❑ WNL
Headaches	❑ YES ❑ NO	
Numbness/tingling sensation	❑ YES ❑ NO	
Weakness or paralysis	❑ YES ❑ NO	
Convulsions or seizures	❑ YES ❑ NO	
Change in memory/concentration	❑ YES ❑ NO	
Loss or blurring of vision or double vision	❑ YES ❑ NO	
Black-outs/dizziness	❑ YES ❑ NO	
Memory loss or confusion	❑ YES ❑ NO	
Other neurological problems	❑ YES ❑ NO	
PSYCHIATRIC		❑ WNL
Nervousness	❑ YES ❑ NO	
Depression	❑ YES ❑ NO	
Other	❑ YES ❑ NO	
RESPIRATORY		❑ WNL
Breathing problems/shortness of breath	❑ YES ❑ NO	
Coughing up blood	❑ YES ❑ NO	
Chronic cough	❑ YES ❑ NO	

Past Medical History:

Have you ever been **diagnosed** with any of the following conditions or had any of procedures listed below? *Check Yes or No. If yes, please give an explanation.*

SYSTEMS	Patient Comments	Physician Comments
CARDIOVASCULAR		
Atrial Fibrillation	❑ YES ❑ NO	
Blood Clotting Disorder	❑ YES ❑ NO	
Carotid Artery Disorder	❑ YES ❑ NO	
Congestive Heart Failure	❑ YES ❑ NO	
Elevated Cholesterol	❑ YES ❑ NO Level ____ Date____	
Heart Murmur	❑ YES ❑ NO	
Heart Attack/Angina	❑ YES ❑ NO	
Heart Surgery/Angioplasty	❑ YES ❑ NO	
High Blood Pressure	❑ YES ❑ NO	
Prosthetic/Artificial Heart Valve	❑ YES ❑ NO	
Blockage of Arm or Leg Blood Vessels	❑ YES ❑ NO	
GASTROINTESTINARY/ GENITOURINARY/RESPIRATORY		
Stomach Ulcers	❑ YES ❑ NO	
Liver Disease/Hepatitis	❑ YES ❑ NO	
Kidney/Bladder Disease	❑ YES ❑ NO	
Lung Disease	❑ YES ❑ NO	
Tuberculosis	❑ YES ❑ NO	
OTHER		
Alcohol Dependency	❑ YES ❑ NO	
Cancer	❑ YES ❑ NO	
Diabetes	❑ YES ❑ NO	
Drug Abuse	❑ YES ❑ NO	
Immune System Disorder	❑ YES ❑ NO	
Thyroid Disease	❑ YES ❑ NO	
Toxic Exposure	❑ YES ❑ NO	
Sexually Transmitted Disease	❑ YES ❑ NO	

Other Medical Problems: (Please list all medical conditions not listed above)

Surgical History/Previous Operations/Hospitalizations:

Date	Hospital	Problem/Operation

Current Medications:

Please list any medications (prescription and non-prescription) you are currently taking (including Vitamins and Aspirin).

Medications	Dosage/Amount	Number of times taken daily

Allergy History:

Have you ever had an allergic reaction to any medication? ❑ Yes ❑ No If yes, please list medication and reaction.

_____

Social History:

Birthplace:_____ Highest grade completed in school: _____

Current Occupation: _____

Relationship/marital status: _____

Who currently lives at home with you? _____

Have you ever smoked cigarettes: ❑ Yes ❑ No

If yes, how much do you currently smoke per day? ❑ None ❑ ½ pack ❑ 1 pack ❑ > 1 pack

If you previously smoked, how long ago did you quit? ❑ 1 year ❑ 1 - 5 years ❑ > 5 years

How many years did you smoke? _____

Have you had significant exposure to: Pesticides? ❑ Yes ❑ No Toxic Waste? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No Type_____ How often/much? _____

Do you exercise? ❑ Yes ❑ No

If yes, how much? ❑ Rarely ❑ Occasionally ❑ > 3 times per week

Dietary restrictions? ❑ Yes ❑ No

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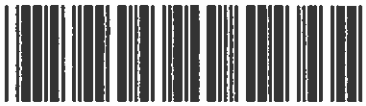

CLINICS • CARDIOVASCULAR •
NEW PATIENT QUESTIONNAIRE

Family History:

Family member	Age (or age at death)	Sex	Living	Medical Problems
Grandparents	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
Father	_____		❑ Yes ❑ No	_____
Mother	_____		❑ Yes ❑ No	_____
Siblings	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
Children	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____
	_____	❑ M ❑ F	❑ Yes ❑ No	_____

_____ _____ _____

Patient Signature **Print Name** **Date**

Person completing form if other than patient: _____ **Relationship:** _____

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key finding(s) with the patient and/or family.

Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.

Key findings = positive responses or pertinent negatives

Attending MD: _____ Print Name: _____ Date: _____ Time: _____

Also reviewed by: _____ Print Name: _____ Date: _____ Time: _____