

NEW PATIENT VISIT

Granbury

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Other Physicians: _____

Patient

WHY ARE YOU HERE TO SEE A CARDIOLOGIST?

Clinician

History of Present Illness: (HPI) New Problem Existing Problem (CLINICIAN ONLY)

Include the following elements: Location, Quality, Severity, Duration, Timing, Context, Modifying factors, and associated signs and symptoms. Brief = 1-3

Elements Extended = 4+ elements or status of 3+ chronic/inactive condition

Patient

Clinician

Social History:

Where were you born? (City, State)

Marital Status: (circle one)

Single Married Divorced Widowed OTHER:

Do you have any children? Yes No
How many?

Are you retired? Yes No
Occupation:

Do you smoke? Yes No, but used to Never

When did you quit?

How many packs do (or did) you smoke and for how many years? (example- 1 pack/day for 20 years)

Do you drink alcohol? Yes No, but used to Never

If you used to drink, when did you quit?

How much do you drink in an average week? (circle one)

0-1 drinks/week 1-5 6-10 10+

Have you ever been treated for drug dependency? Yes No
Type(s):

Are you following any special diet? Yes No
If yes, specify:

Do you drink caffeine? Yes No
Type: Coffee Tea Cola OTHER:

Do you exercise daily? Yes No
Type(s):

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Past Medical History:

Are you allergic to any medications? If yes, please list:	Yes	No
Are you allergic to iodine, shrimp, or shellfish?	Yes	No
Have you ever received X-Ray contrast in your veins? (e.g. Myelogram, Kidney series, CAT scan, etc.) If yes, did you have a problem with this?	Yes	No
Have you ever had a blood transfusion? If yes, when?	Yes	No
Have you ever had any operations or surgeries? If yes, please list what type and approximate date:	Yes	No
Women: Are you post-menopausal? If yes, are you taking hormonal replacement (estrogen)?	Yes	No
	Yes	No

Family History:

Father's Age:	or age at death:		
Mother's Age:	or age at death:		
Siblings: (brothers & sisters)			
1.	Age:	or age at death:	
2.	Age:	or age at death:	
3.	Age:	or age at death:	
4.	Age:	or age at death:	
5.	Age:	or age at death:	
Medical Problems: (Check if yes)	Father:	Mother:	Siblings:
Heart Attack			
Stroke			
Diabetes			
High Blood Pressure			
Angina			
Other Family members with heart problems: (example: paternal uncle, 55yo, pacemaker)			
Family/Social History = PFSH Pertinent PFSH = At least 1 specific item from either Past Family or Social Complete PFH = All			

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Pharmacy: _____ Location: _____

MEDICATIONS:

Please list **ALL** of the medications that you are taking at home. Include all prescription medications, non-prescription medications, vitamins, and supplements.

NAME OF MEDICATION	DOSAGE/STRENGTH	HOW MANY/HOW OFTEN
<i>e.g. Lasix</i>	<i>40 mg</i>	<i>1 tablet 3 times/day</i>

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Review of Systems:

The following questions relate to health problems you **HAVE** or **HAVE HAD** in the past. Please check **YES** or **NO**.

Patient

Clinician

	YES	NO
1. Constitutional:		
Weight Loss		
Weight Gain		
Fever		
Fatigue		
2. Eyes:		
Glaucoma		
Cataracts		
3. Cardiovascular:		
Chest Pain		
Shortness of Breath		
Edema (swelling)		
Palpitations		
4. Respiratory:		
Chronic cough/sputum		
Wheezing		
Asthma		
Bronchitis/Emphysema		
Tuberculosis		
Pneumonia		
5. Gastrointestinal:		
Stomach Ulcers		
Hiatal Hernia		
Hepatitis or Yellow Jaundice		
Gallstones or Gallbladder Disease		
Chronic Constipation or Diarrhea		
Diverticulitis		
6. Venous:		
Swelling in your legs, ankles or feet		
Pain, aching or heaviness in your legs		
Redness or warmth in your legs		
Masses or lumps in your legs		
Bulging varicose veins		
Previous blood clot in your legs		
7. Renal		
Kidney Stones		
Frequent Kidney or Bladder Infections		
Do you have to get up at night to urinate?		
How many times?		
Kidney Failure		

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Review of Systems: (cont.)

Patient

Clinician

	YES	NO	Initial:
8. Musculoskeletal:			
Gout			
Arthritis			
Cramping legs when walking			
9. Endocrine:			
Hypertension			
Diabetes			
High Cholesterol or fats in the blood			
Thyroid Problems or Goiter			
10. Neurological:			
Seizure Disorder			
Numbness			
Stroke			
11. Hematological			
Easy Bruising			
Bleeding			

Please note any other health problems you have, not covered by this list.

CLINICIAN ONLY BELOW

Review of Systems (ROS)

Problem Pertinent ROS:	Positive & Pertinent Negative responses related to problem			
Extended ROS:	Positive & Pertinent Negative responses for 2 – 9 systems			
Complete ROS:	Positive & Pertinent Negative responses for at least 10 systems			
History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family and/or Social History (PSFH)	Type of History	Codes #'s
Brief	N/A	N/A	Problem Focused	99212
Brief	Problem Pertinent	N/A	Expanded Problem	99213
Extended	Extended	Pertinent	Detailed	99214
Extended	Complete	Comprehensive		