

# NEW PATIENT VISIT

**Pecan Plantation**

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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Patient

Clinician

## 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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**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	
<b>1. Constitutional:</b>			
Weight Loss			
Weight Gain			
Fever			
Fatigue			
<b>2. Eyes:</b>			
Glaucoma			
Cataracts			
<b>3. Cardiovascular:</b>			
Chest Pain			
Shortness of Breath			
Edema (swelling)			
Palpitations			
<b>4. Respiratory:</b>			
Chronic cough/sputum			
Wheezing			
Asthma			
Bronchitis/Emphysema			
Tuberculosis			
Pneumonia			
<b>5. Gastrointestinal:</b>			
Stomach Ulcers			
Hiatal Hernia			
Hepatitis or Yellow Jaundice			
Gallstones or Gallbladder Disease			
Chronic Constipation or Diarrhea			
Diverticulitis			
<b>6. Venous:</b>			
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			
<b>7. Renal</b>			
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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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

## Review of Systems: (cont.)

Patient

Clinician

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