**Princeton Interventional Cardiology, P.A. New Patient Problem List**

**Office Visit Examination Page 1 of 3**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your answers on this form will help your health care provider better understand your medical concerns and conditions better.

**Main reason for today’s visit** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other concerns you wish to address** **during today’s examination** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF LAST VISIT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you received a pneumococcal vaccine? Yes No If yes, date of vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU EXPERIENCED THE FOLLOWING SYMPTOMS?**

**PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:**

Chest pain/pressure/discomfort Yes No

Palpitations Yes No

Shortness of breath with exertion Yes No

Shortness of breath at rest Yes No

Foot, calf, buttock, hip or thigh discomfort (aching, tingling, cramping or pain) when you walk which

Is relieved by rest ? Yes No

Do you experience any pain at rest in your lower legs or feet? Yes No

Recent sweats/fever Yes No

Unexplained weight loss Yes No

Unexplained weight gain Yes No

Unexplained fatigue/weakness Yes No

Cough/Wheeze Yes No

Dizziness, lightheadedness, passing out Yes No

Nausea or Vomiting Yes No

Headaches Yes No

Visual Problems Yes No

Hearing difficulties Yes No

Abdominal Pain Yes No

Heartburn, indigestion Yes No

Change in Bowel Habits Yes No

Diarrhea Yes No

Constipation Yes No

Black stools or blood in stool Yes No

Burning or Pain with urination Yes No

Urinating frequently Yes No

Urinating during the night Yes No

Blood in urine Yes No

Muscle pain , if yes (location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Yes No

Joint pain, if yes (location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Yes No

Skin rash, if yes (location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Yes No

Difficulty sleeping Yes No

How many hours a night sleep do you receive on average \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours

**Princeton Interventional Cardiology, P.A.**

**Office Visit Examination Page 2 of 3**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Thank You.

Do you follow a special diet, ie. Fat free, salt free, diabetic, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly, if so approximately how many hours per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Medications are you currently taking, including over-the-counter medications?

Medication Dose How many times per day

Have you had an surgeries or hospitalizations in the past, please indicate:

Do you currently smoke or chew tobacco? Yes \_\_\_\_\_\_\_\_\_ No

If yes, how many packs per day \_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a history of smoking; but have quit, how long ago did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently drink coffee or tea? Yes No

If yes, number of cups per day \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently drink alcohol, beer or wine? Yes No

If yes, how many drinks per week \_\_\_\_\_\_\_\_\_\_\_\_\_

**Princeton Interventional Cardiology, P.A.**

**Office Visit Examination Page 3 of 3**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History:**

**Living Age (or age at death) Illnesses**

Mother Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother(s) Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister(s) Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has any member of your family (including children, parents, siblings, aunts or uncles) had any of the following illnesses?**

**Illness Family Member**

Anemia or Blood Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peripheral Vascular Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you completed a living will or durable power of attorney for health care? Yes No**