Center for Clinical Cardiovascular Care at Mount Sinai Heart
1111 Amsterdam Avenue
New York, NY 10025

New Patient Questionnaire

Demographics and Appointment Information:

Demographics

Today's Date: _____ **Patient Date-of-Birth:**_____
Patient Last Name:_____ **Social Security Number:**_____
Patient First Name:_____ **Gender:**_____ **Marital Status:**_____
Street Address:_____ **City:**_____ **State:**____ **Zip Code:**_____
Phone #: _____(h) _____(m) **E-Mail:**_____
Employer:_____ **Employer Address:**_____
Emergency Contact:_____ **Emergency Contact Relationship:**_____
Emergency Contact Home #:_____ **Emergency Contact Cell #:**_____

Physician Information

Primary Care Physician (PCP) Name:_____ **PCP Office Address:**_____
PCP Office #:_____
Referring MD Name:_____ **Referring MD Address:**_____
Referring MD #:_____
Other MD Name:_____ **Other MD Address:**_____
Other MD #:_____

Primary Insurance Information

Insurance Company:_____ **Effective Date:**_____
Policy #:_____ **Group #:**_____ **Name of Insured:**_____
Patient Relationship to Insured:_____

Secondary Insurance Information

Insurance Company:_____ **Effective Date:**_____
Policy #:_____ **Group #:**_____ **Name of Insured:**_____
Patient Relationship to Insured:_____

Guarantor Information (if different than self)

Last Name:_____ **First Name:**_____
Social Security Number:_____ **Gender:**_____ **Marital Status:**_____
Street Address:_____ **City:**_____ **State:**____ **Zip Code:**_____
Phone #: _____(h) _____(m) **Date of Birth:**_____
Employer:_____ **Employer Address:**_____

Pharmacy Information

Local Pharmacy Name:_____ **Pharmacy Phone #:**_____
Pharmacy Address:_____

Mail Order Pharmacy Name: _____ **Pharmacy Phone #**: _____
Pharmacy Address: _____ **Pharmacy Fax #:** _____

Why are you here today:

_____

_____

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Patient Name: _____

Past Medical History: Please check ***only*** the boxes that apply to you

Heart Diagnoses:

- ☐ Abnormal electrocardiogram (EKG)
- ☐ Abnormal heart valve
- ☐ Angina (Chest Pain)
- ☐ Atrial fibrillation
- ☐ Enlarged heart
- ☐ Coronary artery disease
- ☐ Defibrillated/shocked
- ☐ Endocarditis (infected heart valve)
- ☐ Heart attack/myocardial infarction
- ☐ Heart disease you were born with
- ☐ Heart Failure/ cardiomyopathy
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Hospitalized for cardiac reasons
- ☐ Irregular heart rate (arrhythmia)
- ☐ Previous cardiac arrest
- ☐ Pericardial disease

Lung Diagnoses:

- ☐ Asthma/bronchitis
- ☐ COPD/emphysema
- ☐ Sleep apnea (heavy snoring)

Blood Vessel Diagnoses:

- ☐ Aneurysm
- ☐ Blood clots in leg(s) (DVT)
- ☐ Carotid disease
- ☐ Leg Pain
- ☐ Leg Swelling
- ☐ Pulmonary embolus (blood clot in lungs)
- ☐ Stroke
- ☐ TIA (mini-stroke)
- ☐ Vascular disease (pain in legs while walking)
- ☐ Varicose veins

Ulcers:

Have you ever had an ulcer on your leg or foot?

☐ Yes ☐ No

If yes, please complete below questions:

Where is your ulcer? _____

When did your ulcer first appear? _____

What dressings do you use to treat your ulcer?

_____

Who changes your dressing? _____

Other:

- ☐ Diabetes
- ☐ Kidney disease
- ☐ Kidney failure/dialysis
- ☐ Liver disease
- ☐ Rheumatic fever
- ☐ Thyroid disease

Hospitalizations:

_____

_____

_____

Current Medications

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

	Name of Medication	Dose/Strength	How Many/How Often/When
Example	*Lasix*	*40 mg*	*twice a day - morning and night*
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Patient Name: _____

Allergy History

Please list any medications, or materials you are allergic to, had an adverse reaction to, or do not tolerate and describe the reaction. _____

_____

Procedure History:

Please check ***only*** the boxes that apply to you and put the date you had the procedure on the line:

Heart

- ☐ Angioplasty or stent _____
- ☐ Cardiac catheterization _____
- ☐ Cardiac CT or MRI _____
- ☐ Coronary Artery Bypass Surgery (CABG) _____
- ☐ Echocardiogram _____
- ☐ Heart rhythm ablation _____
- ☐ Heart transplant _____
- ☐ Holter monitor _____
- ☐ ICD (defibrillator insertion) _____
- ☐ Left Ventricular Assistance Device(LVAD) _____
- ☐ Lung transplant _____
- ☐ Pacemaker Insertion _____
- ☐ Stress test _____
- ☐ Anesthesia reaction (specify) _____

Vascular

- ☐ Balloon or stent of leg _____
- ☐ Leg Bypass surgery _____
- ☐ Aortic aneurysm repair _____
- ☐ Laser vein procedure _____
- ☐ Removal of vein _____
- ☐ Vein injections _____
- ☐ Blood flow study in legs _____
- ☐ Ultrasound of the legs _____
- ☐ Ultrasound of the carotid _____
- ☐ Ultrasound of the aorta _____

Other surgeries

_____

_____

_____

Family History: Please check if any members of your family have had any of the following conditions:

Condition	Father	Mother	Sister(s)	Brother(s)	Child(ren)
Aneurysm					
Blood Clots					
Cancer (specify type)					
Diabetes					
Heart Attack					
Heart Disease					
Heart Failure/ Cardiomyopathy					
Sudden/Unexpected Death					
Stroke/TIA (mini stroke)					
Vascular Disease (specify					
Venous Disease					

Social History: Please check the box if you consume any of the following and indicate frequency of use:

- ☐ Alcohol Use_____
- ☐ Caffeine Use _____
- ☐ Tobacco Use_____(packs)_____(years)__
- ☐ Recreational Drug Use _____

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Physical Activity: Please check the box for the frequency which you exercise each week

☐ None/Sedentary ☐ 3 – 5 Times Per Week ☐ Daily ☐ Physically Unable to Exercise

Check off the activities below that you can do with relative ease:

☐ Climb 1-2 flights of stairs
☐ Get dressed
☐ Have a long talk
☐ Take a short walk (e.g. less than one block)
☐ Take a longer walk (e.g. around the block)
☐ Take a bath

Review of Symptoms: Please check the box if you have presented any of the following symptoms during the past 2 months

Heart:
☐Chest pain
☐Chest pressure
☐Palpitations
Breathing:
☐Awakening with breathing difficulty
☐Difficulty breathing while lying flat
☐Shortness of breath
☐Snoring

Other:
☐Back pain
☐Blood in urine or stools
☐Change in vision
☐Change in weight
☐Coughing up blood
☐Fever
☐Headaches
☐Hearing Loss
☐Nearly passing out spells
☐Numbness/tingling in hands or feet
☐Passing out spells
Vascular:
☐ Swelling of the feet or ankles
☐ Pain in the legs while walking
☐ Pain in the feet while lying flat
☐ Sudden loss of vision in one eye
☐ Sudden weakness in arm/leg

My records may be included in research studies with a guarantee that my name and personal identifiers will remain anonymous. Yes ___ No___

Patient Signature _____ Date of signature _____