Weill Cornell Medicine | NewYork-Presbyterian
Cardiothoracic Surgery

PATIENT INITIAL VISIT SELF-ASSESSMENT FORM

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**

Date of Visit: _____

Patient Information:

Name:	Date of Birth:
Cell Phone:	Preferred Email:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ❑ Separated ❑ Domestic Partner		
Spouse/Significant Other:	Patient's Occupation	Patient's Language Preference

Referral information:

How were you referred to us?	☐ WEBSITE ☐ HEALTH PLAN DIRECTORY ☐ FAMILY/FRIEND ☐ PHYSICIAN ☐ INTERNET ☐ PHYSICIAN REFERRAL SERVICE ☐ CORNELL WEBSITE ☐ INTERNATIONAL OFFICE ☐ CENTER FOR PERFORMING ARTS ☐ BROCHURE ☐ OTHER Please Specify: _____

Referring Physician:	Phone	Fax:
Address:		
Primary Care Physician	Phone	Fax:
Address:		
Pulmonologist	Phone	Fax:
Address:		
Gastroenterologist	Phone	Fax:
Address:		
Cardiologist	Phone	Fax:
Address:		

Other Doctors You Want Your Records To Be Sent To:

Health Information:

Reason for today's visit:
Other diseases and / or problem:

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

	YES	NO	If Yes, When?		YES	NO	If Yes, When?
Angina				Pneumonia			
Angioplasty				Acid Reflux			
Arrhythmia				Barrett's Esophagus			
Heart Attack				Ulcers			
Congestive Heart Failure				Diabetes			
Coronary Artery Disease				Thyroid Disorder			
Mitral Valve Prolapse				Liver Disease			
High Blood Pressure				Hepatitis/Jaundice			
High Cholesterol				Kidney Dysfunction			
Atrial Fibrillation				Dialysis			
Stroke				Cancer/Tumors			
Seizure				Arthritis/Joint Pain			
Vascular Disease				Depression/Anxiety			
Deep Vein Thrombosis				Glaucoma			
Blood Clot in Lungs				Leg Swelling			
Blood Clot in Lungs							
Asthma				Others / Comments			
Emphysema/COPD							
Tuberculosis							

HAVE YOU EVERY HAD SURGERY? ❑ Yes ❑ No

(If yes, please list the type of surgery and when you had it done)

Have you ever been hospitalized for any reason other than surgery?

Social History:

Do you smoke? ☐ Yes ☐ No	Cigarettes/Cigars/Pipe?	How many packs a day?	How many years?
Did you smoke? ☐ Yes ☐ No	Quit? ❑ Yes ❑ No	If yes, when did you quit?	
Do you drink alcohol? ☐ Yes ☐ No	Type of Alcohol:	How many drinks a week?	
Do you use recreational drugs? ☐ Yes ☐ No	If yes, please specify:	☐ IV ☐ Smoke ☐ Intranasal	
Do you exercise regularly? ☐ Yes ☐ No	How often?	What type of exercise?	
What is your Height?		What is your Weight?	
Last Blood Pressure (if known)			

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Family History:

Please list any medical conditions: (specify history of cancer, heart disease, stroke, diabetes, etc.?)

Maternal Grandmother	Alive?	❑	Yes	❑	No
Maternal Grandfather	Alive?	❑	Yes	❑	No
Paternal Grandmother	Alive?	❑	Yes	❑	No
Paternal Grandfather	Alive?	❑	Yes	❑	No
Mother	Alive?	❑	Yes	❑	No
Father	Alive?	❑	Yes	❑	No
Sister	Alive?	❑	Yes	❑	No
Brother	Alive?	❑	Yes	❑	No
Daughter	Alive?	❑	Yes	❑	No
Son	Alive?	❑	Yes	❑	No
Other/Comments	Alive?	❑	Yes	❑	No

REVIEW OF SYSTEMS *please circle, if any of the following apply*

Constitutional	❑ Fatigue	❑ Insomnia	❑ Weight Change	❑ Fever	❑ Chills
Eyes	❑ Vision Changes	❑ Pain	❑ Floaters		
Ear, Nose, Throat #1	❑ Sore Throat	❑ Ringing in Ears (Tinnitus)		❑ Ear Pain	
Ear, Nose, Throat #2	❑ Nasal Congestion	❑ Difficulty in Swallowing			
Cardiovascular #1	❑ Chest Pain	❑ Palpitations	❑ Lightheaded	❑ Swelling (Edema)	
Cardiovascular #2	❑ Leg/Calf Pain	❑ Fainting	❑ Shortness of Breath when laying		
Respiratory #1	❑ Shortness of Breath during activity		❑ Sputum	❑ Blood in Sputum	
Respiratory #2	❑ Coughing	❑ Wheezing		❑ Sleep Apnea	
Gastrointestinal #1	❑ Nausea	❑ Vomiting	❑ Diarrhea	❑ Abdominal Pain	
Gastrointestinal #2	❑ Constipation	❑ Dyspepsia	❑ Reflux	❑ Blood in Vomit	
Musculoskeletal	❑ Arthritis	❑ Myalgia		❑ Bone Pain	
Genitourinary	❑ Urinary Retention	❑ Incontinence	❑ Urgency	❑ Painful Urination	
Genitourinary	❑ Blood in Urine	❑ Urine Frequency	❑ Urethral Discharge	❑ Nocturia	
Integumentary	❑ Rashes	❑ Skin Ulcers	❑ Alopecia	❑ Skin Changes	
Neurologic #1	❑ Weakness	❑ Memory Loss	❑ Convulsions		
Neurologic #2	❑ Vertigo	❑ Unusual Headaches	❑ Tremor		
Endocrine #1	❑ Blood Glucose Level	❑ Heat intolerance			
Endocrine #2	❑ Cold intolerance	❑ Excessive Urinating	❑ Excessive Thirst		
Hematology/ Lymphatic	❑ Easy Bruising	❑ Easy Bleeding			
Hematology/ Lymphatic	❑ Swelling or enlarged lymph nodes		❑ Anticoagulation use		
Allergy	❑ Hives	❑ Anaphylaxis	❑ Angioedema	❑ Raynaud's Disease	
Psychiatric	❑ Depression	❑ Anxiety	❑ Hallucination	❑ Suicidal ideation	

Immunizations

Did you have your Flu Vaccine?	Date		❑	Yes	❑ No
Did you have Pneumonia Vaccine?	Date		❑	Yes	❑ No

The information is accurate and complete to the best of my knowledge.
I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.

Patient Signature: Name of person completing form (if not patient): Signature: Today's Date	Physician Signature: Today's Date: