



**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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Spouse/Significant Other:	Patient's Occupation	Patient's Language Preference

**Referral information:**

How were you referred to us?	<input type="checkbox"/> WEBSITE <input type="checkbox"/> HEALTH PLAN DIRECTORY <input type="checkbox"/> FAMILY/FRIEND <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> INTERNET <input type="checkbox"/> PHYSICIAN REFERRAL SERVICE <input type="checkbox"/> CORNELL WEBSITE <input type="checkbox"/> INTERNATIONAL OFFICE <input type="checkbox"/> CENTER FOR PERFORMING ARTS <input type="checkbox"/> BROCHURE <input type="checkbox"/> OTHER   Please Specify: _____	
<b>Referring Physician:</b>	Phone	Fax:
Address:		
<b>Primary Care Physician</b>	Phone	Fax:
Address:		
<b>Pulmonologist</b>	Phone	Fax:
Address:		
<b>Gastroenterologist</b>	Phone	Fax:
Address:		
<b>Cardiologist</b>	Phone	Fax:
Address:		

<b>Other Doctors You Want Your Records To Be Sent To:</b>

**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 EVER HAD SURGERY?  Yes  No

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

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

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**Social History:**

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

**Family History:**

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

Maternal Grandmother	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Maternal Grandfather	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Paternal Grandmother	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Paternal Grandfather	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Mother	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Father	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Sister	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Brother	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Daughter	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Son	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Other/Comments	Alive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

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

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

**Immunizations**

Did you have your Flu Vaccine?	Date	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have Pneumonia Vaccine?	Date	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:
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