Weill Cornell Medicine
Cardiothoracic Surgery
NewYork-Presbyterian

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:

Patient's Full Name:	Patient's Date of Birth:
Cell Phone:	Preferred Email:

Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner	
Emergency Contact:	Cell Phone:	Relationship to Patient:

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's Name:	Phone	Fax:
Address:		
Primary Care Physician's Name	Phone	Fax:
Address:		
Cardiologist's Name	Phone	Fax:
Address:		

Other Doctors You Want Your Records to Be Sent To: (Please provide Full Name, Address, Phone Number, Specialty)

Health Information:

Reason for today's visit:

Social History:

Did you ever smoke? ☐ Yes ☐ No	Type: ☐ Cigarette ☐ Cigars ☐ Pipe ☐ Smokeless tobacco	How many packs a day?	How many years?
Did you quit? ☐Yes (When________) ☐ No	Do you use recreational drugs? ☐ Yes ☐ No	Type:	
Do you drink alcohol? ☐ Yes ☐ No	Type:	How many drinks a week?	
What is your Height?	What is your Weight?	Last Blood Pressure?	

Immunizations

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

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

Constitutional	❑ Fatigue	❑ Weight Change	❑ Fever	❑ Chills	
Ear, Nose, Throat #1	❑ Sore Throat	❑ Ringing in Ears			
Ear, Nose, Throat #2	❑ Nasal Congestion	❑ Nose Bleed	❑ Mouth Sores		
Eyes	❑ Vision Changes	❑ Eye Pain	❑ Floaters		
Respiratory #1	❑ Shortness of Breath	❑ Chest Tightness	❑ Coughing		
Respiratory #2	❑ Wheezing	❑ Sleep Apnea			
Cardiovascular #1	❑ Chest Pain	❑ Palpitations	❑ Leg Swelling (Edema)		❑ Leg/Calf Pain
Gastrointestinal #1	❑ Nausea	❑ Vomiting	❑ Diarrhea	❑ Constipation	
Gastrointestinal #2	❑ Stomach Pain	❑ Reflux	❑ Vomiting Blood	❑ Blood in stool	
Endocrine #1	❑ Elevated Glucose Level	❑ Heat intolerance		❑ Cold intolerance	
Endocrine #2	❑ Excessive Urinating	❑ Excessive Thirst			
Genitourinary #1	❑ Blood in Urine	❑ Incontinence	❑ Urgency	❑ Painful Urination	
Genitourinary #2	❑ Erectile Dysfunction	❑ Nocturia	❑ Urine Frequency	❑ Urethral Discharge	
Musculoskeletal	❑ Arthritis	❑ Aching Muscles	❑ Bone Pain	❑ Gout	
Integumentary	❑ Rashes	❑ Skin Ulcers	❑ Hair Loss	❑ Skin Changes	
Allergy	❑ Food Allergies	❑ Environmental Allergies		❑ Immuno Compromised	
Neurologic #2	❑ Convulsions/Seizures	❑ Vertigo	❑ Numbness	❑ Tremor	❑ Lightheaded
Hematology	❑ Easy Bruising	❑ Easy Bleeding	❑ Swelling or enlarged lymph nodes		
Hematology	❑ Anemia	❑ Anticoagulation use			
Psychiatric	❑ Depression	❑ Anxiety /Nervous	❑ Hallucination	❑ Suicidal ideation	
	❑ Insomnia	❑ Sleep Disturbance			

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING

	YES	NO		YES	NO
Acid Reflux/GERD			Heart Valve Disorder		
Acute Arterial Occlusion			Heart Attack		
Angina			Hepatitis/Jaundice		
Angioplasty			High Blood Pressure/ Hypertension		
Aortic Aneurysm or Dissection			High Cholesterol		
Arrhythmia			Kidney/Renal Disease		
Asthma			Dialysis		
Atrial Fibrillation			Leg Swelling		
Barrett's Esophagus			Liver Disease		
Blood Clot - DVT			Peripheral Vascular Disease		
Cancer/Tumors			Pneumonia		
Claudication			Pulmonary Embolism		
Coronary Artery Disease			Seizure		
Congestive Heart Failure			Stomach Ulcers		
Depression/Anxiety			Stroke		
Diabetes (Insulin/No Insulin)			TIA (Transient Ischemic Attack)		
Emphysema COPD			Thyroid Disorder/Disease		
Glaucoma			Tuberculosis		
Others / Comments:					

Family History:

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

Mother	
Father	
Siblings	
Children	
Other/Comments	

Surgical History: ☐ **YES** ☐ **NO** **If yes, please see below**

Type of Surgery	Date	Hospital
Angioplasty or Stent		
Amputation		
Aortic Aneurysm Repair		
Appendectomy		
Bypass (Extremities)		
CABG (Bypass Surgery)		
Cardiac Catheterization		
Carotid Endarterectomy		
Gastric Surgery		
Gallbladder Removal		
Lung Surgery		
Surgery for Cancer		
Tonsillectomy		
Valve Stent		
Other Surgery:		

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