

Connecticut Cardiothoracic Surgical Associates, L.L.C.

As a new patient, please fill out the information found below to the best of your ability.

Patient # _____ Physician _____ Date _____

Patient name _____ Chief complaint _____

History of Present Illness:

Location _____ (Where is the pain/problem?) Quality _____ (Example: normal versus abnormal color, activity, etc.)

Severity _____ (How severe is the pain/problem on a scale of 1 - 5 [5 being the most severe]) Duration _____ (How long have you had this pain/problem, or when did it start?)

Timing _____ (Does this pain/problem occur at a specific time?) Context _____ (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms (What other associated problems have you been having?) _____

Modifying Factors (What makes the pain/problem worse or better? Have you had previous episodes?) _____

Patient Medical History:

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bronchitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mumps	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of last chest x-ray: _____		
Chickenpox	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Whooping Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mitral Valve Prolapse	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Scarlet Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Polio	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diphtheria	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Smallpox	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Ulcer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood or Plasma Transfusions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rheumatic Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Back Trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Thyroid Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	High or Low Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding Tendency	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hemorrhoids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Any Other Disease (please list) _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Venereal Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hives or Eczema	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Bladder Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes	AIDS or HIV+	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Infectious Mono	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State/Prov.
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (include nonprescription): _____

No Yes Have you ever taken Fen-Phen/Redux?
 No Yes Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?
 No Yes Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?

Patient Social History:

Marital status: Single Married Separated Divorced Widowed
 Use of alcohol: Never Rarely Moderate Daily
 Use of tobacco: Never Previously, but quit: _____ Current packs/day _____
 Use of drugs: Never Type/frequency: _____
 Excessive exposure at home or work to: Fumes Dust Solvents Airborne particles Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

- Good general health lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

EYES

- Eye disease or injury No Yes
 Wear glasses/contact lenses No Yes
 Blurred or double vision No Yes

EARS/NOSE/MOUTH/THROAT

- Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problems or rhinitis No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

CARDIOVASCULAR

- Heart trouble No Yes
 Chest pain or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath walking or lying flat No Yes
 Swelling of feet, ankles or hands No Yes

RESPIRATORY

- Chronic or frequent coughs No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

GASTROINTESTINAL

- Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements or constipation No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal pain No Yes

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X _____ Date _____
 Signature of patient (or parent/guardian if minor)

GENITOURINARY

- Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of strain when urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male - testicle pain No Yes
 Female - pain with periods No Yes
 Female - irregular periods No Yes
 Female - vaginal discharge No Yes
 Female - # of pregnancies: _____
 Female - # of miscarriages: _____
 Female - date of last pap smear: _____

MUSCULOSKELETAL

- Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

INTEGUMENTARY (skin, breast)

- Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

NEUROLOGICAL

- Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Convulsions or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Head injury No Yes

PSYCHIATRIC

- Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

ENDOCRINE

- Glandular or hormone problem No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming dryer No Yes
 Change in hat or glove size No Yes

HEMATOLOGIC/LYMPHATIC

- Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

- Penicillin or other antibiotics No Yes
 Morphine, Demerol, or other narcotics No Yes
 Novocain or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin or other serums No Yes
 Iodine, merthiolate or other antiseptics No Yes

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

Doctor's Review: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Date _____
Signature of Doctor _____	Date _____