CAPE REGIONAL PHYSICIANS ASSOCIATES

CRPA Cardiology

Name: _____ Date of Birth: _____

Cardiology New Patient Information

Date: _____

Primary Care Physician: _____

Medication: Please list all medications with dose and frequency.
(Please include non-prescription medications, vitamins, and supplements)

Medication	**Dose**	**Frequency** (i.e., how many times daily?)	**Prescribed By**

Pharmacy: Where would you like us to send your prescriptions?
Local pharmacy name, location: _____
Mail order pharmacy name: _____

Do you take any of the following blood Thinners? (Circle any that apply):
Aspirin, Ibuprofen-based products (Ex. Motrin, Advil), Coumadin, Lovenox, Plavix, Xarelto, Pradaxa

Do you need any medication refills today? If so please list:

_____

Allergies: Please list ALL medication, food, and/or environmental allergies, and specify reaction type that occurs (i.e. rash, itching).

Have you ever had an anaphylactic reaction (severe, near deadly reaction)?: (Circle) Yes / No

Family History: Please note any serious family medical history

Check all that apply:

Atrial Fibrillation	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Aneurysm	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Coronary Artery Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister
CVA	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Diabetes	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Heart Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister
High Blood Pressure	☐ Mom	☐ Dad	☐ Brother	☐ Sister
High Cholesterol	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Kidney Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Lung Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Peripheral Vascular Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Sudden Cardiac Death	☐ Mom	☐ Dad	☐ Brother	☐ Sister
Valvular Heart Disease	☐ Mom	☐ Dad	☐ Brother	☐ Sister

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Social History: Please circle the following that apply to you:

Are you: Single Married Divorced Other

Are you sexually active? Yes No

What is your employment/occupation? _____

Please outline your use of the following products, past or present:

Product	Current Use? Yes/No	Daily Amount	Weekly Amount	Past Use? Yes/No
Tobacco				
What did you use to smoke? ____ cigarettes, ____ pipe, ____ cigars, ____ chewing tobacco				
Alcohol				
Recreational Drugs				
Caffeine				

Do you use other forms of nicotine products? (circle) smokeless tobacco, electronic cigarettes? _____

Immunization:

Immunization up to date?	Yes/No	When?
Flu Vaccine this year?	Yes/No	
Pneumonia	Yes/No	
Tetanus	Yes/No	
Pertussis	Yes/No	
Zostavax	Yes/No	
History of Blood Transfusion?	Yes/No	

Do you have a Living Will/Advance Directive? _____

Past Surgical History/Past Procedures:

_____

_____

Recent Hospitalization(s):

_____

_____

Current and/or Previous Medical Specialists: (Name/Specialty)

_____

_____

Recent Diagnostic Studies: (within the last 3 years)

1. Heart Testing (Type / Where / When) _____
   - Cardiac Catheterization (Where / When) _____
   - ECHO (Where / When) _____
   - EKG (Where / When) _____
   - Holter Monitor (Where / When) _____
   - Stress Test (Where / When) _____
2. Lung Testing (Type / Where / When) _____
3. X-Ray (Where / When / Specify Body Part) _____
4. Ultrasound (Where / When / Specify Body Part) _____
5. CT (Where / When / Specify Body Part) _____
6. MRI (Where / When / Specify Body Part) _____
7. Biopsy (Where / When / Specify Body Part) _____
8. Other (Type / Where / When) _____
9. Most Recent Blood Testing/Labs (Where / When) _____

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Health Maintenance: Please note the most recent date you received any of the below health services.

Service	Date (Month/Year)	Physician
Yearly Physical		
Eye Exam (If **Dilated** Eye Exam, please specify)		
Dental Exam		
Pap Smear		
Prostate Exam		
Mammogram		
Colonoscopy		
Diabetic Foot Exam		

Review of Systems: (Please circle symptoms that are currently present)

General Symptoms: fatigue, weight change, change in appetite, medication changes
Head, Eye, Ear, Nose, and Throat: vertigo, headache, vision changes, snoring, facial numbness
Skin: rash, itching, skin changes, open areas
Respiratory: Cough, shortness of breath, wheezing, decreased exercise tolerance, chronic cough
Cardiovascular: chest pain, rapid heartbeat, palpitations, irregular heartbeat, swelling in limbs, shortness of breath with activity, hypertension, low blood pressure, chest pressure, difficultylaying down or at night, fainting, pain in legs, swelling in legs,
Gastrointestinal: Nausea, vomiting, constipation, diarrhea, heartburn
Genitourinary: Urinary retention, urgency
Musculoskeletal/Neck: muscle pain, cramping, joint swelling, joint pain, muscle weakness
Neurological: stroke, numbness, weakness, fainting, difficulty walking, speaking, headaches, tingling, dizziness, loss of consciousness
Hematology: abnormal bleeding, easy bruising, anemia, night sweats
Other: _____

Reason(s) for visit today:

_____

_____

Do you have any question(s) for the provider?

_____

_____

_____

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Medical History: Please circle any health condition that applies to you and specify/comment if needed. If you have any questions, please ask a member of our staff for assistance. Thank you.

Medical History (For "Other," Please Specify)	**Specify/Comments**
Alcohol/Drug Problem	
Breast Lump, Other breast problem	
Cardiac Angina, Cardiomyopathy, Congestive Heart Failure, Endocarditis, Heart attack, Heart Disease, High blood pressure, High cholesterol, Pacemaker, Valve problem, Other	
Cancer Brain, Breast, Cervical, Colon, Lung, Parathyroid, Ovarian, Prostate, Rectal, Skin, Stomach, Throat, Thyroid, Uterine, Other	
Digestive/Stomach Barrett's Esophagus, GERD, Hernia, Intestinal problem, Liver Disease, Ulcer, Other	
Endocrine Diabetes, Thyroid Disease, Goiter, Other	
Hematology Anemia, Bleeding disorder, Clotting disorder, Other	
Immune Disorder AIDS, HIV, Lupus, Other	
Kidney Disease, Kidney stone, Other kidney problem	
Musculoskeletal Arthritis/Joint problem, Hernia, Osteoporosis/Osteopenia, Other	
Neurological Nerve Disease, Stroke, Other	
Psychiatric Anxiety, Depression, Insomnia, Sleep walking, Other	
Respiratory Asthma, Bronchitis, COPD, , Chronic lung disease, Emphysema, Obstructive sleep apnea, Pneumonia, Other	
Skin Eczema, Psoriasis, Other	
Urinary / Reproductive Abnormal pap test, Bladder problem, Menstrual abnormality, Prostate problem, Sexually transmitted infection, Other	
Vascular (Arteries, veins): Aneurysm,	
Other Medical History: Gout, Injury, Lyme, Hepatitis A / B / C, Tuberculosis, Scarlet fever, Ulcer, other	

Signature of patient or guardian Printed name of patient or guardian Date