CardioVascular Institute of Scottsdale

Please fill out the Initial Patient Information Survey, and bring the following items.
[1]Completed Initial Patient Information Survey, [2] Insurance card.

First Name: _____

Last Name: _____ *DOB:* _____

Reason for Visit: _____

Referring physician: _____

*Pharmacy Name*_____

*Location:*_____

Please provide the medications you currently take with dosage and frequency

_____
_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

Please indicate any current/past medical conditions.

Circulatory System Conditions

- ☐ *Abdominal Aortic Aneurysm*
- ☐ *Atrial Fibrillation*
- ☐ *Dysrhythmia (rhythm abnormalities)*
- ☐ *Carotid Artery Disease*
- ☐ *Congestive Heart Failure*
- ☐ *Heart Transplant*
- ☐ *Hyperlipidemia (high cholesterol)*
- ☐ *Hypertension (high blood pressure)*
- ☐ *Mitral Valve Pro lapse*
- ☐ *Myocardial Infarction (heart attack)*
- ☐ *Coronary Artery Disease*
- ☐ *Peripheral Vascular Disease (PAD)*
- ☐ *Varicose Veins*

Endocrine & Metabolic Conditions

- ☐ *Diabetes Type I*
- ☐ *Diabetes Type II*
- ☐ *Hypothyroidism (underactive thyroid)*

Gastrointestinal Conditions

- ☐ *GERD (Reflux Disease)*
- ☐ *Hiatal Hernia*

Pulmonary Conditions

- ☐ *Asthma*
- ☐ *COPD / Emphysema*

Please list any other medical conditions you have not listed above.

_____
_____
_____
_____

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ALLERGIES

Do you have any allergies to medications? If yes, please indicate name/s and reaction.

☐ *No known medication allergies*

Medication	***Reaction***

PREVIOUS SURGERIES

Please provide a list of previous surgeries.

☐ *None.* _____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please fill out your family medical history below:

Family Member	***Alive***	***Current Age OR Age at Death***	***Cause of Death***	***Medical Conditions***
Mother	*YES / NO*			
Father	*YES / NO*			
Maternal Grandmother	*YES / NO*			
Maternal Grandfather	*YES / NO*			
Paternal Grandmother	*YES / NO*			
Paternal Grandfather	*YES / NO*			
Brothers	*YES / NO*			
Sisters	*YES / NO*			

_____

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SOCIAL HISTORY

Personal Relations

Occupation/Current job: _____

☐ *Unemployed* → *Last job:* _____

☐ *Retired* → *Last job:* _____

Marital Status: ☐ *Single* / ☐ *Married* / ☐ *Partnered* ☐ *Separated* / ☐ *Divorced* / ☐ *Widowed*

Tobacco Use

Do you now or have you ever been a cigarette/cigar smoker? ☐ *Yes*, ☐ *No*

Years smoked: _____, *Packs/Day:* _____

If you quit, when (Date)? _____

Frequency Cigar Smoking: _____

Frequency Chew Tobacco: _____

Alcohol Consumption

Do you consume alcohol? _____

If no, have you ever been a drinker: _____ *Sober since:* _____

Type: ☐ *Beer* ☐ *Hard Liquor* ☐ *Wine*

Frequency: _____

Caffeine Consumption

Type: ☐ *None* ☐ *Coffee* ☐ *Tea* ☐ *Soda* ☐ *daily chocolates* ☐ *energy drinks*

Frequency: _____

Recreational Drugs

Do you currently or have you used recreational drugs? ☐ *NO* / ☐ *YES*

*If YES, drugs Used/frequency:*_____

*Date quit:*_____

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REVIEW OF SYSTEMS: *Please indicate yes or no to the following symptoms.*

General/Constitutional	***No***	***Yes***
Change in Appetite		
Chills/Fever		
Fatigue/Weakness		
Night Sweats		
Weight Gain		
Weight Loss		
Eyes	***No***	***Yes***
Blurred Vision/Loss of Vision		
Dry Eye		
Itching and redness		
Red Eye		
Ears/Nose/Throat	***No***	***Yes***
Decreased Hearing		
Difficulty Swallowing		
Ear Pain		
Nosebleed		
Ringing in the Ears		
Digestive System	***No***	***Yes***
Abdominal pain		
Blood in Stool		
Constipation		
Diarrhea		
Difficulty Swallowing		
Heartburn		
Hematemesis		
Nausea/Vomiting		
Skin	***No***	***Yes***
Blistering of Skin		
Discoloration		
Eczema		
Itching		
Rash		
Sun Sensitivity		

Hematology	***No***	***Yes***
Easy Bruising		
Prolonged Bleeding		
Recent Blood Transfusion		
Swollen Glands		
Respiratory	***No***	***Yes***
Cough		
Spitting out blood		
Shortness of Breath at Rest		
Shortness of Breath with Exertion		
Sputum Production		
Wheezing		
Cardiovascular	***No***	***Yes***
Chest Pain at Rest		
Chest Pain with Exertion		
Difficulty Laying Flat		
Dizziness/Lightheadedness		
Fluid accumulation in the Legs		
Palpitations		
Musculoskeletal	***No***	***Yes***
Joint Stiffness		
Leg Cramps		
Muscle Aches		
Swollen Joints		
Peripheral Vascular	***No***	***Yes***
Blanching of Skin		
Cold Extremities		
Decreased Sensation in Extremities		
Painful Extremities		
Pain/Cramping in Legs After Exertion		
Ulceration of Feet		
Neurologic	***No***	***Yes***
Balance Difficulty		
Fainting		
Gait Abnormality		
Loss of Strength		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremor		

Signature_____

Date _____