

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: _____

Signature of Doctor _____ Date _____