CCSG — New Patient Visit Form (page 1) DATE:

Staff to Complete This Section

Patient Name: _____ **AGE:** ____ **MR Number:** _____

Preferred Pharmacy: _____

Primary Care and/or Other Providor(s):_____

Vital Signs (seated)**: BP** (Rt) _____ (Lt) _____ **HR** _____ **Resp** _____ **Ht** _____ **Wt** _____

Vital Signs (standing, if patient reports dizziness, lightheadedness, or syncope): **BP** _____ **HR** _____

Reason for Referral:

_____

_____

Past Medical History (circle all that apply):

Heart Attack	High Blood Pressure	Colon Disease
Coronary Artery Disease	High Cholesterol	Anemia or Bleeding Disorder
Congestive Heart Failure	Diabetes	Cancer
Heart Murmur or Valve Disease	COPD/Emphysema	HIV or AIDS
Abnormal Heart Rhythm	Stomach Ulcers	Blood Clot (DVT or PE)
Stroke or TIA (mini-stroke)	Thyroid Disease	Arthritis
Peripheral Artery Disease	Kidney Disease	Neurologic Disorder
Carotid Artery Disease	Liver Disease	

Others: _____

Prior Surgeries (please list and include approximate dates):

_____

_____

_____

Previous Cardiac or Vascular Testing / Procedures (Please include approximate dates):

EKG	Carotid Ultrasound	Peripheral Artery Bypass or Stents
Holter or Event Monitor	Carotid Stent or Surgery	Heart Catheterization
Pacemaker or Defibrillator	Abdominal Ultrasound (Aorta)	Coronary Stent(s)
Stress Test	Peripheral Vascular Test	Coronary Artery Bypass Grafting
Echocardiogram	Peripheral Angiography	

CCSG — New Patient Visit Form (page 2) Name/MR#: _____

Social History:

Where do you live?_____ Marital Status: _____ Occupation: _____

Do you drink alcohol? Yes or No What kind, how much, and how often? _____

Smoking history: Never Former (Quit when? _____) Current (How much? _____ packs per day)

Caffeinated beverages per day? _____ Exercise (type, frequency, and duration)?_____

Family History (Have any immediate family members been diagnosed with the following: Heart Attack, Stents or Bypass Surgery, Heart Failure, Stroke, or Sudden Death. Include approximate age at time of diagnosis.)

Father _____ **Living** **Deceased**

Mother _____ **Living** **Deceased**

Other(s) _____ **Living** **Deceased**

Current Medications (Please include prescription, over-the-counter, and supplements):

Drug Name	**Dosage**	**When Do You Take (circle all that apply)**		
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**
		Morning	**Mid-Day**	**Bedtime**

Do you have any Allergies, Drug Intolerances, Iodine/Contrast Reactions or Problems with Anesthesia?

_____

_____

CCSG — New Patient Visit Form (page 3) Name/MR#: _____

Review of Systems (Please circle any of the following symptoms that you experience.)

Loss of Appetite
Fatigue
Fever
Tire Easily
Weight Gain
Weight Loss
Easy Bruising
Itching
Skin Rashes
Headaches
Blurry or Double Vision
Ringing in Ears
Hearing Loss
Runny Nose
Bloody Nose
Neck Pain
Neck Stiffness
Shortness of Breath
Cough
Coughing up Blood
Snoring
Coughing up Mucous

Wheezing
Chest Pain
Short of Breath Lying
Short of Breath w/ Exertion
Dizziness
Passing Out
Lightheadedness
Palpitations
Short of Breath at Rest
Swelling of the Legs
Abdominal Pain
Black or Tarry Stools
Difficulty Swallowing
Bloody Stools
Constipation
Diarrhea
Nausea
Vomiting
Vomiting Blood
Blood in Urine
Difficult Urination
Difficulty with Erections

Incontinence
Painful Urination
Arthritis
Back Pain
Fatigability in Legs
Heaviness of Legs
Leg Cramps
Leg Pain
Muscle Weakness
Memory Problems
Numbness
Weakness
Slurred Speech
Unsteadiness
Anxiety
Depression
Easily Irritated
Insomnia
Nervousness
Panic Attacks