CARDIOVASCULAR GROUP

Gwinnett Medical Center

Main Line: 470.325.1000 **cvgcares.com**

NEW PATIENT FORM

Date: _____ Account: _____

Patient Name: _____ Date of Birth: _____

Consent to release record information:

In the event CVG needs to contact you regarding your Medical Records or Appointment, please list the telephone numbers and email at which you may be reached:

Home _____ Cell _____

Work _____ Email _____

In the event you are not available:

Do you authorize CVG to give test result(s) to your family member(s)?	○ Yes	○ No
May we leave a message on your voice mail or answering machine?	○ Yes	○ No
May we send you text messages on your cell phone?	○ Yes	○ No

Name to whom can release	**Relationship**	**Phone Number**
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People excluded from obtaining records: _____

Password: _____ (last 4 digits of Social Security Number)

Security Question: _____ (Mother's Maiden Name)

Signature: Date:

Download the New Patient Form. Please complete the entire form (5 pages). Once completed, email this form to: Yoneli Williams (ywilliams12@gwinnettmedicalgroup.com). Please be sure to attach the completed PDF form to your email and send.

NEW PATIENT QUESTIONNAIRE

Name: _____

Date of Birth: _____ Age: _____

Weight: _____ Height: _____

1. Describe in your own words why you need to see a cardiologist.

_____

_____

_____

2. Past medical illnesses:

Have you ever had any of the following medical problems? If so, when?

Heart attack	◯ yes	◯ no	_____
Stroke	◯ yes	◯ no	_____
High blood pressure	◯ yes	◯ no	_____
Cancer	◯ yes	◯ no	_____
Asthma	◯ yes	◯ no	_____
Diabetes	◯ yes	◯ no	_____
Ulcers	◯ yes	◯ no	_____
Vascular disease	◯ yes	◯ no	_____
Rheumatic fever	◯ yes	◯ no	_____
Mitral valve prolapse	◯ yes	◯ no	_____
Hepatitis	◯ yes	◯ no	_____
Thyroid disease	◯ yes	◯ no	_____
Kidney disease	◯ yes	◯ no	_____
Endocarditis	◯ yes	◯ no	_____
Emphysema	◯ yes	◯ no	_____
Hiatal hernia	◯ yes	◯ no	_____
Gallbladder disease	◯ yes	◯ no	_____
Elevated cholesterol	◯ yes	◯ no	_____
Sleep apnea	◯ yes	◯ no	_____
Atrial fibrillation	◯ yes	◯ no	_____

3. Past surgical history:

Please list any surgical procedures along with the date.

4. Have you ever had a cardiac catheterization, angioplasty, stress test, or treadmill study? If so, when and where?

5. Please list all medications you are presently taking, along with the dosage (strength) and frequency (number of times per day).

6. Please list all over-the-counter medications you are presently taking. For example: decongestants, diet pills, pain pills or antihistamines.

7. Have you ever used Redux or Phen-Fen? ◯ Yes ◯ No

Explain:

8. Are you allergic to any medications. If so, please list the medication as well as the type of reaction.

9. Have you ever smoked? ◯ Yes ◯ No If so, for how many years?

How many packs per day? When did you quit?

10. Do you consume alcoholic beverages? ◯ Yes ◯ No If so, how many drinks per day?

11. Do you consume caffeine? If so, how much?

12. Have you ever used any recreational drugs? If so, what type?

13. Do you have a family history of heart disease? ◯ Yes ◯ No

If so, please list which family member, type of heart disease and age that they were diagnosed.

14. What is your occupation? _____

15. Overall system review:

Have you had recent fever or shaking chills?	◯ yes	◯ no
Have you had recent unexplained weight loss or weight gain?	◯ yes	◯ no
Have you ever passed out?	◯ yes	◯ no
Do you suffer from migraines or frequent headaches?	◯ yes	◯ no
Have you ever had temporary blindness or double vision?	◯ yes	◯ no
Do you have difficulty swallowing?	◯ yes	◯ no
Do you suffer from nosebleeds?	◯ yes	◯ no
Have you ever had vertigo (severe dizziness)?	◯ yes	◯ no
Do you suffer from chronic coughing or wheezing?	◯ yes	◯ no
Do you suffer from shortness of breath?	◯ yes	◯ no
Have you ever coughed up blood?	◯ yes	◯ no
Have you ever experienced chest pain or chest tightness?	◯ yes	◯ no
Do your feet and ankles swell?	◯ yes	◯ no
How many pillows do you use to sleep?		
Do you have palpitations (skipping or racing heartbeat)?	◯ yes	◯ no
Do you have problems with constipation?	◯ yes	◯ no
Do you have problems with diarrhea?	◯ yes	◯ no
Have you ever passed black, tarry bowel movement?	◯ yes	◯ no
Do you have difficulty in urinating?	◯ yes	◯ no
Do you have pain or burning upon urination?	◯ yes	◯ no
Have you ever had blood in your urine?	◯ yes	◯ no
Do you have any form of arthritis?	◯ yes	◯ no
Do you have leg pain when you walk?	◯ yes	◯ no
Have you ever had seizures or tremors?	◯ yes	◯ no
Do you have any rashes related to medications?	◯ yes	◯ no
Do you have any ulcers on your feet?	◯ yes	◯ no
Have you recently experienced unusual anxiety or stress?	◯ yes	◯ no
Date of last menstrual period		

16. Who is your family doctor? _____

17. What pharmacy do you use? Please give telephone number also. _____

18. List any other physicians that you use. _____

19. Have you had any procedures, x-rays, or blood work done recently? ☐ yes ☐ no
If so, name of test and where performed.

20. Why are you here today?

☐ Doctor(Name) _____ requested that I see a cardiologist.

☐ New patient visit ☐ Pre-operative evaluation ☐ Hospital follow-up

☐ Other: _____

Patient signature: _____ Date: _____

Physician signature: _____ Date: _____

REVIEW OF SYSTEMS

Please help us keep your information up to date. Check only the symptoms that apply. If none of these symptoms are present, then leave it blank.

General/Constitutional:	◯ Recent fever	◯ Recent chills
Eyes:	◯ Recent blurred vision	◯ Recent double vision (diplopia)
Ears, Nose, Mouth, Throat:	◯ Recent hearing loss	◯ Recent nosebleed (epistaxis)
Respiratory:	◯ Shortness of breath (dyspnea)	◯ Shortness of breath while lying flat (orthopnea)
Cardiovascular:	◯ Chest pain	◯ Palpitations
	◯ Peripheral edema	◯ Dizziness
	◯ Light headedness	◯ Have you passed out?
Gastrointestinal:	◯ Recent rectal bleeding (hematochezia)	◯ Recent black stools (melena)
Muscoloskeletal:	◯ Recent muscle weakness	◯ Recent muscle pain or muscle cramps
Neurological:	◯ Recent TIA	◯ Recent change in cognitive functions
Psychiatric:	◯ Recent substance abuse	◯ Recent change in cognitive functions
Hematiological/ Immunologic:	◯ Recent easy bruising	◯ Recent bleeding disorders

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