Cardio Medical Consultants Group

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New Patient Evaluation Form

Name: _____ Date of Birth: _____ Age: _____
Sex ☐ Male ☐ Female
Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other _____
☐ Decline to report
Preferred Language: _____
Responsible Party (if a minor) _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____ Fax #: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____

Name of Primary Medical Insurance: _____
Insurance ID #: _____ Group #: _____
Name of Secondary Medical Insurance: _____
Insurance ID #: _____ Group #: _____

Primary Care Physician: _____
Referring Physician (if different): _____

Pharmacy name and location: _____

Emergency contact name: _____
Relationship to patient: _____

What is the reason for your appointment today?
_____
_____

LIFESTYLE

Relationship/Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Do you have children: ☐ No ☐ Yes If yes, how many? _____
Current Occupation: _____ ☐ Not Employed ☐ Retired
Do you exercise? ☐ No ☐ Yes
If yes, what activity _____ How often _____
Advance Directive: ☐ None ☐ Do not resuscitate
Durable Power of Attorney: ☐ No ☐Yes, _____ Relationship to self: _____
Living Will: ☐ None ☐ Yes Health Care Proxy: ☐ None ☐ Yes, _____

PAST MEDICAL AND SURGICAL HISTORY

☐ Established Coronary Artery Disease (Heart Attack, Coronary Stents, Coronary Artery Bypass Grafting)
☐ Peripheral artery disease
☐ Atrial fibrillation or Atrial Flutter
☐ Congestive heart failure
☐ Bleeding disorder _____
☐ High blood pressure (hypertension) or on treatment
☐ Diabetes mellitus:
☐ Type 1 ☐ Type 2
☐ Thyroid disorder _____
☐ Systemic autoimmune collagen-vascular disease (Lupus, Rheumatoid arthritis)
☐ Depression
☐ Sleep Apnea
☐ Thoracic or abdominal aortic aneurysm
☐ Other heart rhythm disorder _____
☐ Heart Valve problem or heart murmur_____
☐ Clotting disorder or history of blood clots _____
☐ High cholesterol/ on treatment for high cholesterol
☐ Chronic kidney disease/ End Stage Renal Disease / Hemodialysis
☐ Liver disease _____
☐ Polycystic Ovarian Syndrome
☐ Transient Ischemic Attack (TIA) or Stroke
☐ Cancer _____
☐ COPD/ asthma/ reactive airway disease
☐ Non-cardiac surgery _____
☐ Other medical issues _____

PRIOR CARDIOVASCULAR TESTS AND PROCEDURES

☐ Electrocardiogram (ECG)
☐ Coronary Artery Calcium or Cardiac CT
☐ Cardiac MRI
☐ Stress test
☐ Angiogram/heart catheterization
☐ Aortic aneurysm repair/stenting
☐ Pacemaker
☐ Bioimpedence
☐ Carotid ultrasound
☐ Peripheral arterial ultrasound
☐ Holter monitor or Event monitor
☐ Heart Valve Repair or Replacement
☐ Peripheral artery bypass surgery
☐ Implanted Cardiac Defibrillator (ICD)
☐ Echocardiogram/TEE
☐ Abdominal aortic ultrasound
☐ Peripheral venous ultrasound
☐ Electric Physiology Study
☐ Carotid artery surgery/ stenting
☐ Congenital heart disease repair

PREGNANCY AND MENOPAUSE HISTORY

☐ Preeclampsia
☐ Pregnancy induced hypertension
☐ Preterm birth or birth of infant small for gestational age
☐ Age at menopause _____
☐ Spontaneous abortion or miscarriage
☐ Gestational diabetes
☐ History of hormone replacement therapy

FAMILY HISTORY

Family History	Age(s)	Diseases	If deceased, cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____

SOCIAL HISTORY

Have you ever smoked cigarettes? ☐ No ☐ Yes
If yes, how much do you currently smoke a week? ☐ None ☐ ½ pack ☐ 1 pack ☐ >1 pack
If you previously smoked, how long ago did you quit? ☐ <1 year ☐ 1-5 years ☐ > 5 years
How many years did you smoke? _____
Do you drink alcohol? ☐ Never ☐ Former/Year Quit _____
☐ Yes Type of alcohol _____ Drinks per week _____
Do you use illicit drugs? ☐ No ☐ Yes Type of illicit drug_____ Date last used_____

REVIEW OF SYSTEMS

GENERAL

Fever	☐ No	☐ Yes	Chills	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes	Sleeping problem	☐ No	☐ Yes
Weight loss	☐ No	☐ Yes	Weight gain	☐ No	☐ Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss	☐ No	☐ Yes	Ringing in the ears	☐ No	☐ Yes
Pain in the ears	☐ No	☐ Yes	Nasal congestion	☐ No	☐ Yes
Runny nose	☐ No	☐ Yes	Nose bleeds	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes	Blurry vision/vision loss	☐ No	☐ Yes

CARDIOVASCULAR

Chest pain	☐ No	☐ Yes	Palpitations	☐ No	☐ Yes
Light headedness or dizziness	☐ No	☐ Yes	Loss of consciousness	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes	Leg swelling	☐ No	☐ Yes
Leg muscle pain with walking	☐ No	☐ Yes	Decreasing exercise tolerance	☐ No	☐ Yes

RESPIRATORY

Cough	☐ No	☐ Yes	Phlegm	☐ No	☐ Yes
Coughing blood	☐ No	☐ Yes	Wheezing		

GASTROINTESTINAL

Nausea	☐ No	☐ Yes	Vomiting	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes	Diarrhea	☐ No	☐ Yes
Heart burn/acid reflux	☐ No	☐ Yes	Blood in the stool	☐ No	☐ Yes
Constipation	☐ No	☐ Yes			

GENITOURINARY

Pain with urination	☐ No	☐ Yes	Need to urinate frequently	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes	Urinary incontinence	☐ No	☐ Yes
Frequent urination at night	☐ No	☐ Yes	Impotence	☐ No	☐ Yes

MUSCULOSKELETAL

Pain in the joints	☐ No	☐ Yes	Muscle pain	☐ No	☐ Yes
Back problems	☐ No	☐ Yes	Difficulty walking	☐ No	☐ Yes

NEUROLOGIC

Headaches	☐ No	☐ Yes	Shaking	☐ No	☐ Yes
Numbness	☐ No	☐ Yes	Weakness	☐ No	☐ Yes
Seizures	☐ No	☐ Yes	Memory loss	☐ No	☐ Yes

ENDOCRINE

`Hot or cold intolerance	☐ No	☐ Yes	Excessive thirst	☐ No	☐ Yes

HEMATOLOGIC

Easy bleeding	☐ No	☐ Yes	Easy bruising	☐ No	☐ Yes
Swollen glands/lymph nodes	☐ No	☐ Yes			

DERMATOLOGIC

Rash	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes
Hair loss	☐ No	☐ Yes	Change in skin/nails	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

Diffuse itching	☐ No	☐ Yes	Anaphylaxis	☐ No	☐ Yes

PSYCHIATRIC

Depressed mood	☐ No	☐ Yes	Anxiety	☐ No	☐ Yes
Hallucinations	☐ No	☐ Yes	Suicidal thoughts	☐ No	☐ Yes

ALLERGY HISTORY

Have you ever had an allergic reaction to any medication? ☐ No ☐ Yes

If yes, please list medication and reaction_____

Are you allergic to iodine? ☐ No ☐ Yes

Please list all other allergies (food, environmental allergies, animals, etc) _____

_____

MEDICATIONS

Routine medications	Dosage	Number of times taken a day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins or herbs _____

Other Alternative medications or therapies _____

As needed medications (ASA, NSAIDS, Tylenol) _____

History of diet pills _____

For additional medications, please list them below.

Cardio Medical Consultants Group

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562 904-6027

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Suite 401
Lynwood, CA 90262
310 604-0443

MEDICAL RELEASE

Medical Record #:_____ Patient name:_____ Date of Birth: _____

The purpose of this release is:

☐At the request of the patient/patient representative ☐ Other (state reason): _____

Notice

Cardio Medical Consultants Group and many other organizations that individuals such as physicians, hospitals and health plans are required by law to keep your information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

My Rights

- I understand this authorization is voluntary. Treatment, payment enrollment and eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the Health Information Managements Services, Cardio Medical Consultants Group, 3737 martin Luther King jr Blvd, Suite 401, Lynwood, CA 90262. The revocation will take effect when Cardio Medical Consultants Group receives it, except to the extent that Cardio Medical Consultants group or others have already relied on it.
- I am entitled to receive a copy of the Authorization.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires _____ (insert applicable date of event). If no date is indicated, the Authorization will expire 12 months after the date of signing.

TO:

_____

_____

_____

TYPE OF RECORD:

_____

_____

_____

I hereby request that my medical records be sent to the above physician.

SIGNATURE

_____ Date: _____

(Signature of Patient or Patient's Legal Representative)

_____ Time: _____AM/PM

Printed Name

Phone Number Include Area code)

(If signed by someone other than the patient, state your relationship to the patient/authority)

Witness (Only if patient unable to sign) or Interpreter