

PATIENT INITIAL VISIT SELF-ASSESSMENT FORM

Please Note: All information is confidential and will become part of your medical record
 Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**

Date of Visit: _____

Patient Information:

Patient's Full Name:	Patient's Date of Birth:
Cell Phone:	Preferred Email:

Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Spouse/Significant Other:	Patient's Occupation	Patient's Language Preference

Referral information:

How were you referred to us?		
<input type="checkbox"/> WEBSITE <input type="checkbox"/> HEALTH PLAN DIRECTORY <input type="checkbox"/> FAMILY/FRIEND <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> INTERNET <input type="checkbox"/> PHYSICIAN REFERRAL SERVICE <input type="checkbox"/> CORNELL WEBSITE <input type="checkbox"/> INTERNATIONAL OFFICE <input type="checkbox"/> CENTER FOR PERFORMING ARTS <input type="checkbox"/> BROCHURE <input type="checkbox"/> OTHER Please Specify: _____		
Referring Physician's Name:	Phone	Fax:
Address:		
Primary Care Physician's Name	Phone	Fax:
Address:		
Cardiologist's Name	Phone	Fax:
Address:		

Other Doctors You Want Your Records to Be Sent To: (Please provide Full Name, Address, Phone Number, Specialty)

Health Information:

Reason for today's visit:
Other diseases and / or problem:

Social History:

Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type <input type="checkbox"/> Cigarette <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe	How many packs a day?	How many years?
Did you ever smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you quit? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did you quit?	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	How many drinks a week?	
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify	<input type="checkbox"/> IV <input type="checkbox"/> Smoke <input type="checkbox"/> Intranasal	
Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	What type of exercise?	
What is your Height?	What is your Weight?	Last Blood Pressure?	

Family History:

Please list any medical conditions: (specify history of cancer, heart disease, stroke, diabetes, etc.?)

Maternal Grandmother	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Maternal Grandfather	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Paternal Grandmother	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Paternal Grandfather	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mother	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Father	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sister	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brother	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Daughter	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Son	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other/Comments	Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Immunizations

Did you have your Flu Vaccine?	Date	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have Pneumonia Vaccine?	Date	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REVIEW OF SYSTEMS please check, if any of the following apply

Constitutional	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight Change	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills
Eyes	<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Pain	<input type="checkbox"/> Floaters		
Ear, Nose, Throat #1	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Ringing in Ears		<input type="checkbox"/> Ear Pain	
Ear, Nose, Throat #2	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Nose Bleed (Epistaxis)		<input type="checkbox"/> Mouth Sores	
Cardiovascular #1	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling (Edema)	<input type="checkbox"/> Leg/Calf Pain	<input type="checkbox"/> Fainting
Cardiovascular #2	<input type="checkbox"/> Shortness of Breath when laying	<input type="checkbox"/> Lightheaded			
Respiratory #1	<input type="checkbox"/> Shortness of Breath during activity	<input type="checkbox"/> Sputum		<input type="checkbox"/> Coughing	
Respiratory #2	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Snoring		<input type="checkbox"/> Sleep Apnea	
Gastrointestinal #1	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	
Gastrointestinal #2	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Reflux	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Blood in stool	
Musculoskeletal	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Aching Muscles	<input type="checkbox"/> Bone Pain	<input type="checkbox"/> Gout	
Genitourinary #1	<input type="checkbox"/> Urinary Retention	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Urgency	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine
Genitourinary #2	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Nocturia	<input type="checkbox"/> Urine Frequency	<input type="checkbox"/> Urethral Discharge	
Integumentary	<input type="checkbox"/> Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Skin Changes	
Neurologic #1	<input type="checkbox"/> Weakness	<input type="checkbox"/> Headache	<input type="checkbox"/> Memory Loss		
Neurologic #2	<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tremor	
Endocrine #1	<input type="checkbox"/> Elevated Glucose Level	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Cold intolerance		
Endocrine #2	<input type="checkbox"/> Excessive Urinating	<input type="checkbox"/> Excessive Thirst			
Hematology/ Lymphatic #1	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Swelling or enlarged lymph nodes		
Hematology/ Lymphatic #2	<input type="checkbox"/> Anemia	<input type="checkbox"/> Anticoagulation use			
Allergy	<input type="checkbox"/> Hives	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Angioedema	<input type="checkbox"/> Raynaud's Disease	
Psychiatric	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hallucination	<input type="checkbox"/> Suicidal ideation	

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING

	YES	NO	Date		YES	NO	Date
Angina				COPD			
Angioplasty				Pneumonia			
Arrhythmia				Acid Reflux			
Heart Attack				GERD			
Congestive Heart Failure				Barrett's Esophagus			
Coronary Artery Disease				Ulcers			
Mitral Valve Prolapse				Diabetes (Insulin Dependent)			
High Blood Pressure				Diabetes Type II			
High Cholesterol				Diabetic Kidney Problems			
Hypertension				Thyroid Disorder			
Aortic Aneurysm and Dissection				Liver Disease			
Atrial Fibrillation				Hepatitis/Jaundice			
Stroke				ESRD			
Seizure				Renal Diseases			
TIA (Transient Ischemic Attack)				Dialysis			
Peripheral Vascular Disease				Cancer/Tumors			
Claudication				Arthritis/Joint Pain			
Acute Arterial Occlusion				Depression/Anxiety			
Deep Vein Thrombosis				Glaucoma			
Blood Clot - DVT				Leg Swelling			
Pulmonary Embolism							
Asthma				Others / Comments			
Emphysema							
Tuberculosis							

SURGICAL HISTORY: **YES** **NO** If yes, please see below

Type of Surgery	Date	Hospital
Heart Surgery		
Angioplasty		
Coronary Stent		
Aortic Aneurysm Repair		
CABG		
Cardiac Catheterization		
Carotid Endarterectomy		
Surgery for Cancer		
Lung Surgery		
Gastric Surgery		
Tonsillectomy		
Appendectomy		
Gallbladder Removal		
Bypass (Extremities)		
Amputation		
Other Surgery		
Other Hospitalization (other than surgery)		

*The information is accurate and complete to the best of my knowledge.
 I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.*

Patient Signature: Name of person completing form (if not patient): Signature: Today's Date:	Physician Signature: Today's Date:
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