NEW PATIENT VISIT

HEB

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Other Physicians: _____

Patient	WHY ARE YOU HERE TO SEE A CARDIOLOGIST?	Clinician

History of Present Illness: (HPI) New Problem Existing Problem (CLINICIAN ONLY) Include the following elements: Location, Quality, Severity, Duration, Timing, Context, Modifying factors, and associated signs and symptoms. Brief = 1-3 Elements Extended = 4+ elements or status of 3+ chronic/inactive condition

Patient	Clinician

Social History:	
Where were you born? (City, State)	
Marital Status: (circle one) Single Married Divorced Widowed OTHER:	
Do you have any children? Yes No How many?	
Are you retired? Yes No Occupation:	
Do you smoke? Yes No, but used to Never	
When did you quit?	
How many packs do (or did) you smoke and for how many years? (example- 1 pack/day for 20 years)	
Do you drink alcohol? Yes No, but used to Never	
If you used to drink, when did you quit?	
How much do you drink in an average week? (circle one) 0-1 drinks/week 1-5 6-10 10+	
Have you ever been treated for drug dependency? Yes No Type(s):	
Are you following any special diet? Yes No If yes, specify:	
Do you drink caffeine? Yes No Type: Coffee Tea Cola OTHER:	
Do you exercise daily? Yes No Type(s):	

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Patient Name: _____ DOB: _____ Date: _____

Patient	Clinician

Past Medical History:		
Are you allergic to any medications? If yes, please list:	Yes	No
Are you allergic to iodine, shrimp, or shellfish?	Yes	No
Have you ever received X-Ray contrast in your veins? (e.g. Myleogram, Kidney series, CAT scan, etc.) If yes, did you have a problem with this?	Yes Yes	No No
Have you ever had a blood transfusion? If yes, when?	Yes	No
Have you ever had any operations or surgeries? If yes, please list what type and approximate date:	Yes	No
Women: Are you post-menopausal? If yes, are you taking hormonal replacement (estrogen)?	Yes Yes	No No

Family History:				
Father's Age:		or age at death:		
Mother's Age:		or age at death:		
Siblings: (brothers & sisters)				
1.	Age:	or age at death:		
2.	Age:	or age at death:		
3.	Age:	or age at death:		
4.	Age:	or age at death:		
5.	Age:	or age at death:		
Medical Problems: (Check if yes)		Father:	Mother:	Siblings:
Heart Attack				
Stroke				
Diabetes				
High Blood Pressure				
Angina				
Other Family members with heart problems: (example: paternal uncle, 55yo, pacemaker)				
Family/Social History = PFSH Pertinent PFSH = At least 1 specific item from either Past Family or Social Complete PFH = All				

NEW PATIENT VISIT

Patient Name: _____ DOB: _____ Date: _____

Pharmacy: _____ Location: _____

MEDICATIONS:

Please list **ALL** of the medications that you are taking at home. Include all prescription medications, non-prescription medications, vitamins, and supplements.

NAME OF MEDICATION	DOSAGE/STRENGTH	HOW MANY/HOW OFTEN
e.g. Lasix	*40 mg*	*1 tablet 3 times/day*

NEW PATIENT VISIT

Patient Name: _____ DOB: _____ Date: _____

Review of Systems:

The following questions relate to health problems you **HAVE** or **HAVE HAD** in the past. Please check **YES** or **NO**.

	Patient		Clinician
1. Constitutional:	YES	NO	
Weight Loss			
Weight Gain			
Fever			
Fatigue			
2. Eyes:			
Glaucoma			
Cataracts			
3. Cardiovascular:			
Chest Pain			
Shortness of Breath			
Edema (swelling)			
Palpitations			
4. Respiratory:			
Chronic cough/sputum			
Wheezing			
Asthma			
Bronchitis/Emphysema			
Tuberculosis			
Pneumonia			
5. Gastrointestinal:			
Stomach Ulcers			
Hiatal Hernia			
Hepatitis or Yellow Jaundice			
Gallstones or Gallbladder Disease			
Chronic Constipation or Diarrhea			
Diverticulitis			
6. Venous:			
Swelling in your legs, ankles or feet			
Pain, aching or heaviness in your legs			
Redness or warmth in your legs			
Masses or lumps in your legs			
Bulging varicose veins			
Previous blood clot in your legs			
7. Renal			
Kidney Stones			
Frequent Kidney or Bladder Infections			
Do you have to get up at night to urinate?			
How many times?			
Kidney Failure			

NEW PATIENT VISIT

Patient Name: _____ DOB: _____ Date: _____

Review of Systems: (cont.)

Patient	Clinician

8. Musculoskeletal:	YES	NO	Initial:
Gout			
Arthritis			
Cramping legs when walking			
9. Endocrine:			
Hypertension			
Diabetes			
High Cholesterol or fats in the blood			
Thyroid Problems or Goiter			
10. Neurological:			
Seizure Disorder			
Numbness			
Stroke			
11. Hematological			
Easy Bruising			
Bleeding			

Please note any other health problems you have, not covered by this list.

CLINICIAN ONLY BELOW

Review of Systems (ROS)

Problem Pertinent ROS:	Positive & Pertinent Negative responses related to problem
Extended ROS:	Positive & Pertinent Negative responses for 2 – 9 systems
Complete ROS:	Positive & Pertinent Negative responses for at least 10 systems

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family and/or Social History (PSFH)	Type of History	Codes #'s
Brief	N/A	N/A	Problem Focused	99212
Brief	Problem Pertinent	N/A	Expanded Problem	99213
Extended	Extended	Pertinent	Detailed	99214
Extended	Complete	Comprehensive		