CEDARS-SINAI
WOMEN'S HEART CENTER

NEW PATIENT HISTORY

Printing Template Updated 10-19-2012

PATIENT I.D.

Name: _____ Date: _____

Marital Status:

- ❑ Legally married
- ❑ Separated
- ❑ Widowed
- ❑ Divorced
- ❑ Never married
- ❑ Living with significant other

Usual Employment Status:

- ❑ Full-time
- ❑ Retired; Retirement date _____/_____/_____ (mo / day / yr)
- ❑ Part-time
- ❑ Unemployed due to illness
- ❑ Homemaker
- ❑ Unemployed for other reasons

Occupation: _____ *(current or prior to your retirement)*

Height: _____ ft _____ inches Weight: _____ pounds

Highest Level of Education:

- ❑ No schooling beyond the 8th grade
- ❑ Attended high school
- ❑ Completed high school
- ❑ Attended college, trade school, or other training requiring completion of high school
- ❑ Attended post-graduate training
- ❑ Completed post-graduate training

Ethnicity:

- ❑ Asian
- ❑ Black
- ❑ Caucasian
- ❑ Hispanic
- ❑ Native American
- ❑ Other _____

Physicians: Name *(list each type of physician below)*: Phone Number:

Primary Care _____ _____

Does this physician monitor your cholesterol level? ❑ Yes ❑ No

Cardiologist _____ _____

Does this physician monitor your cholesterol level? ❑ Yes ❑ No

Surgeon _____ _____

Does this physician monitor your cholesterol level? ❑ Yes ❑ No

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REVIEW OF SYSTEMS

Please check any of the following you have experienced in the last year:

1. **General:**
   - ❑ Weight gain
   - ❑ Weight loss
   - ❑ Fevers
   - ❑ Excessive fatigue
   - ❑ Change in energy level
   - ❑ Night sweats
   - ❑ Chills
2. **Endocrine:**
   - ❑ Feeling of excessive warmth or coldness
   - ❑ Change in the amount you urinate
   - ❑ Feeling of excessive thirst or excessive hunger
3. **Blood and lymphatic:**
   - ❑ Easy bruising
   - ❑ Prolonged or excessive bleeding
   - ❑ Blood clots in your legs
   - ❑ Enlarged lymph nodes
   - ❑ Enlarged tonsils
4. **Mental Health:**
   - ❑ Nervousness
   - ❑ Undue sadness or depression
   - ❑ Thoughts of harming yourself or others
   - ❑ Anxiety
   - ❑ Trouble with your sleep
   - ❑ Thoughts of ending your life
5. **Skin:**
   - ❑ Change in the texture or amount of your hair
   - ❑ New rashes
   - ❑ Sores or changes in any moles
   - ❑ Changes in your skin or nails
   - ❑ Lumps
6. **Eyes:**
   - ❑ Changes in vision
   - ❑ Double vision
   - ❑ Blurry vision
   - ❑ Red or painful eyes
7. **Ears:**
   - ❑ Changes in hearing
   - ❑ Ringing in your ears
   - ❑ Pain or drainage from ears
   - ❑ Dizziness with or without changes in head position
8. **Nose and sinuses:**
   - ❑ Increase in frequency of colds or nasal drainage
   - ❑ Sinus infections
   - ❑ Nosebleeds
   - ❑ Allergies
9. **Mouth, throat, and teeth:**
   - ❑ Tongue or mouth sores
   - ❑ Hoarseness or voice changes
   - ❑ Bleeding of gums
   - ❑ Recent dental work
   - ❑ Problems swallowing
10. **Neck:**
    - ❑ Lumps
    - ❑ Pain
    - ❑ Swelling
11. **Breasts / Chest:**
    - ❑ Tenderness
    - ❑ Nipple discharge
    - ❑ Lumps
    - ❑ Milk production

(please turn over)

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12. **Respiratory:**
- ❑ New cough
- ❑ Wheezing or shortness of breath
- ❑ Coughing blood
- ❑ Pain with breathing

13. **Cardiac:**
- ❑ Chest pain
- ❑ Palpitations/Unusual heart beat
- ❑ Swelling in your ankles
- ❑ Fainting or passing out spells
- ❑ Pressure or unusual feeling in chest
- ❑ Shortness of breath with activity
- ❑ Shortness of breath lying down

14. **Blood vessels:**
- ❑ Pain in your legs with walking
- ❑ Varicose veins
- ❑ Sensitivity or change in color of your fingers or toes with cold temperatures

15. **Gastrointestinal:**
- ❑ Changes in your appetite
- ❑ Trouble swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Abdominal pain
- ❑ Indigestion or constipation
- ❑ Diarrhea
- ❑ Recent change in frequency, consistency, color or appearance of stool
- ❑ Blood in stool
- ❑ Black, tarry appearance of stool

16. **Urinary:**
- ❑ Change in frequency of urination
- ❑ Burning on urination
- ❑ Hesitancy
- ❑ Change in volume of urine or stream
- ❑ Blood in urine
- ❑ Urgency or incontinence *(loss of control of urine)*

17. **Male Genitoreproductive:**
- ❑ Sores on penis
- ❑ Difficulties with erection
- ❑ Pain or masses in testicles

18. **Female Genitoreproductive:**
- ❑ Changes in duration, amount or frequency of menses
- ❑ Hot flashes
- ❑ Painful sexual intercourse
- ❑ Lack of sexual desire
- ❑ Vaginal dryness
- ❑ Vulvar itching

19. **Musculoskeletal:**
- ❑ Muscle weakness
- ❑ Tenderness
- ❑ Pain or swelling in any joints
- ❑ Muscle pain
- ❑ Stiffness

20. **Neurologic:**
- ❑ Headaches
- ❑ Numbness or tingling of hands or feet
- ❑ Difficulty speaking
- ❑ Abnormal movements
- ❑ Recent falls
- ❑ Blackouts or near blackouts
- ❑ Chronic pain
- ❑ Memory loss or difficulty concentrating
- ❑ Weakness
- ❑ Problems with balance

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CORONARY RISK FACTORS

1. How many close blood relatives *(parent, brother, sister, or child)* have had coronary heart disease BEFORE the age of 60?

   # of relatives _____

2. Have you ever been told that you had any of the following:				Year diagnosed	Has it been treated?	
High Blood Pressure	❑ Yes	❑ No	❑ Unsure		❑ Yes	❑ No
Sugar Diabetes	❑ Yes	❑ No	❑ Unsure		❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No	❑ Unsure		❑ Yes	❑ No
High Triglycerides	❑ Yes	❑ No	❑ Unsure		❑ Yes	❑ No

3. a) What was your most recent cholesterol level? _____ ❑ Unknown
   Approximate date? _____/_____/_____

   b) What was your highest cholesterol level? _____ ❑ Unknown
   Approximate date? _____/_____/_____

   c) Have you been told by your physician that your cholesterol level is a problem?
   ❑ Yes ❑ No

4. Did you **ever** smoke cigarettes? ❑ Yes ❑ No
   If *yes*, please answer the following:

   a) How many years did you or have you smoked? _____ years

   b) On the average, at your maximum, how many packs per day did you smoke?

   ❑ Less than ½ pack per day
   ❑ ½ to less than 1 pack per day
   ❑ 1 pack per day
   ❑ Greater than 1 pack per day

5. Have you stopped smoking entirely? ❑ Yes ❑ No
   If *yes*, date stopped: _____/_____/_____ (month / day / year)

   If *no*, please answer the following:
   On the average, how many packs per day do you presently smoke?

   ❑ Less than ½ pack per day
   ❑ ½ to less than 1 pack per day
   ❑ 1 pack per day
   ❑ Greater than 1 pack per day

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6. Do you drink any kind of alcoholic beverages? ❑ Yes ❑ No

If *yes*, please answer the following:

a) How often?
❑ daily ❑ 2-3 times / week ❑ weekly ❑ monthly

b) When you do drink, how many drinks did you have per day?
(1 drink = 4 oz wine or one shot hard liquor or 12 oz beer)

7. **Please answer:**

a) How many servings of **fruit or fruit juice** do you eat **per day**? *(i.e. one piece of fruit, or one cup raw fruit, ½ cup canned fruit or fruit juice)* _____ servings

b) How many servings of **vegetables or vegetable juice** do you eat **per day**? *(i.e. one cup raw or ½ cup cooked vegetables or vegetable juice)* _____ servings

c) How many servings of legumes (dried peas and beans like garbanzo, split peas lentils, etc) do you eat per week? *(i.e. ½ cup cooked beans or one cup bean soup)* _____ servings

8. **Do** you do any of the following activities?

ACTIVITY			In a 14-day period, how many times on average have you been:	About how many minutes did you actually spend on each occasion?
Walking for exercise?	❑ Yes	❑ No		
Jogging or running?	❑ Yes	❑ No		
Hiking?	❑ Yes	❑ No		
Gardening or yard work?	❑ Yes	❑ No		
Aerobics or aerobic dancing?	❑ Yes	❑ No		
Other dancing?	❑ Yes	❑ No		
Calisthenics or general exercise?	❑ Yes	❑ No		
Golf?	❑ Yes	❑ No		
Tennis?	❑ Yes	❑ No		
Bowling?	❑ Yes	❑ No		
Bicycle riding?	❑ Yes	❑ No		
Swimming or water exercises?	❑ Yes	❑ No		
Horseback riding?	❑ Yes	❑ No		
Handball, racquetball, or squash?	❑ Yes	❑ No		
Sexual intercourse?	❑ Yes	❑ No		
Housework?	❑ Yes	❑ No		

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If you have done any other exercises, sports, or physically active hobbies in the past two weeks other than the ones listed above, please list them:

_____

_____

_____

_____

9. Do you perform stress reduction techniques or exercises? *(i.e. breathing exercise, yoga, meditation, prayer)* ❑ Yes ❑ No

   a) How often?
      - ❑ Several times per day
      - ❑ Almost every day
      - ❑ Once or twice a week
      - ❑ Rarely
      - ❑ Never

   b) What type of stress reduction?
      - ❑ Progressive muscle relaxation
      - ❑ Breathing exercise / visualization
      - ❑ Meditation
      - ❑ Prayer
      - ❑ Other: _____

10. Please answer as appropriate, I have experienced stress *(including tension, irritability, anxiety, or sleeping difficulties)* as a result of conditions at work or home:
    - ❑ Never
    - ❑ Sometimes
    - ❑ Often
    - ❑ Always during the past one year
    - ❑ Always during the past 5 years

11. Have you ever been told you have heart disease, if yes when? _____ year ❑ Unknown
    Which of the following happened first? Answer only if applicable
    - ❑ Angina / Chest Discomfort
    - ❑ Abnormal Treadmill stress test or EKG
    - ❑ Coronary Angiogram
    - ❑ Heart Attack
    - ❑ Other

12. Have you ever had anginal pain and/or chest discomfort? ❑ Yes ❑ No

    If yes, approximately when did this begin: _____/_____/_____ (month / day / year)

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13. Have you ever had a HEART ATTACK? ❑ Yes ❑ No
    If *yes*, answer the following: Date: _____/_____/_____ Hospital: _____
    Date: _____/_____/_____ Hospital: _____
    Date: _____/_____/_____ Hospital: _____
    Total # of heart attacks in your life: _____

14. Have you ever had a CORONARY ANGIOGRAM? ❑ Yes ❑ No
    If *yes*, answer the following: Date: _____/_____/_____ Hospital: _____
    Date: _____/_____/_____ Hospital: _____
    Date: _____/_____/_____ Hospital: _____

15. Have you ever had CORONARY BALLOON ANGIOPLASTY, LASER, OR STENT PLACEMENT (PTCA)? ❑ Yes ❑ No
    If *yes*, answer the following: Date: _____/_____/_____ Hospital: _____
    Date: _____/_____/_____ Hospital: _____
    Total # of PTCA's in your life : _____

16. Have you ever had HEART SURGERY? ❑ Yes ❑ No
    If *yes*, answer the following:
    Date: _____/_____/_____ Hospital: _____ Type of surgery: _____
    Date: _____/_____/_____ Hospital: _____ Type of surgery: _____
    Date: _____/_____/_____ Hospital: _____ Type of surgery: _____

17. Have you ever had HEART FAILURE? ❑ Yes ❑ No
    If *yes*, answer the following: Date: _____/_____/_____ Hospital:
    Date: _____/_____/_____ Hospital: _____

18. Have you ever had CARDIOMYOPATHY? ❑ Yes ❑ No
    If *yes*, answer the following: Date: _____/_____/_____ Hospital: _____

19. If you have experienced a cardiac event, were you hospitalized? ❑ Yes ❑ No
    If *yes*, how many days did you spend in the hospital? _____ days
    Date: _____/_____/_____ Hospital: _____

20. What was the date of your most recent EXERCISE STRESS TEST?
    (Answer only if applicable) Date: _____/_____/_____
    Where was it done? _____

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21. What other medical problems have you had?

_____

_____

_____

_____

22. Answer only if appropriate. SINCE your recent surgery, angioplasty, or heart attack, have you had any pain or discomfort above your waist? *(Please answer even if you are entering the program for something other than the above.)* ❑ Yes ❑ No

    If no, please skip to #23. If *yes*, answer the following:

    a) Where does your pain occur?
    - ❑ Center of chest
    - ❑ Left side of chest
    - ❑ Neck or Jaw
    - ❑ Left arm
    - ❑ Other *(specify)*: _____

    b) Does most of your pain or discomfort occur during physical exertion and/or emotional distress? ❑ Yes ❑ No

    c) Does your pain or discomfort most often go away within 10 minutes if you rest or take nitroglycerin? ❑ Yes ❑ No

    d) If you recently had heart surgery, do you think this is incisional pain? ❑ Yes ❑ No

23. Currently, I experience fatigue:
    - ❑ Never
    - ❑ During moderate to strenuous physical activity
    - ❑ During ordinary daily activity
    - ❑ Even at rest

24. Currently, do you experience shortness of breath?
    - ❑ Never
    - ❑ During moderate to strenuous physical activity
    - ❑ During ordinary daily activity
    - ❑ Even at rest

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25. Please answer the following:
    a) Age of first menstrual cycle _____
    Menses regular ❑ Yes ❑ No Date of last menses ____/____/____
    Birth Control Pills (BCP) ❑ Yes ❑ No Name of BCP _____
    Are you breastfeeding ❑ Yes ❑ No Date started ____/____/____
    Number of births: _____
    Age at each pregnancy _____
    b) Has your natural menstruation stopped? ❑ Yes ❑ No
    If yes, at what age did it stop? _____ years old
    c) Do you take estrogen now or have you ever taken estrogen? ❑ Yes ❑ No
    If yes, at what age did you start taking it? _____ years old
    At what age did you stop taking it? _____ years old
    d) Have you had any of the following surgeries? ❑ Yes ❑ No
    (1) Hysterectomy *(removal of the uterus)* _____ years old
    (2) Removal of one ovary _____ years old
    (3) Removal of both ovaries _____ years old
26. Did you have complications of pregnancy?
    ❑ No Pregnancies
    ❑ Yes, high blood pressure
    ❑ Yes, diabetes
    ❑ Yes, toxemia / pre - eclampsic / eclampsia
    ❑ Yes, Baby was born early
27. If you've been diagnosed with breast cancer or have a personal history of breast cancer, please answering the following questions:

Left Breast	Right Breast
❑ Lumpectomy date ____/____/____	❑ Lumpectomy date ____/____/____
❑ Mastectomy date ____/____/____	❑ Mastectomy date ____/____/____
❑ Lymph node removal date ____/____/____	❑ Lymph node removal date ____/____/____
❑ Reconstruction date ____/____/____	❑ Reconstruction date ____/____/____

Did you have additional treatment *(circle)*?
Chemotherapy
Radiation
Anti-estrogen therapy *(such as Tamoxifen, Arimidex)*
Name of the treating Oncologist _____
Name of the Surgeon _____
Name of the Hospital _____

PATIENT'S NAME (PRINT)	SIGNATURE	DATE	TIME
STAFF NAME (PRINT)	**SIGNATURE**	**DATE**	**TIME**