New Patient Form

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NAME: Date: NPFOFSv2021Sept
DOB: Level: 4[ ] 5[ ] PF [ ]

Reason for your initial visit: Please briefly explain in your own words. Use additional patient note page if needed.

Review of Systems:

- Are you fully vaccinated? [ ]Yes Which one?: [ ]Moderna [ ]Pfizer [ ] J and J [ ]NO
- Your overall sense of wellness: [ ]very good [ ]good [ ]fair [ ]poor.
- Are you taking all prescribed medications regularly? [ ]yes [ ]no
- Trying to follow a healthy low salt, low saturated fat, if diabetic - low refined sugar diet? [ ]yes, most of the time [ ]yes, occasionally [ ]no, not usually.
- Frequency of exercise per week: [ ]none [ ]few times [ ]several times [ ]almost daily.
- Level of daily stress: [ ]average [ ]low [ ]high.
- Average hours of sleep: [ ] 6 to 8 hours [ ] less than 6 hours [ ] more than 8 hours.
- Smoke? [ ]No [ ]Yes – [ ]½ pack per day (ppd) [ ]1ppd [ ]more than 1 ppd.
- Drink alcohol? [ ]No [ ]Yes - [ ]occasionally [ ]almost daily
- Constitutional (Health in General) ❑ No Problems. Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats.
- Ears, Nose, Mouth & Throat ❑ No Problems. Difficulty with hearing, ringing in ears, nosebleed, sore throat. Other:
- Heart & Blood Vessels ❑ No Problems. Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:
- Respiratory. (Lungs & Breathing) ❑ No Problems. Shortness of breath, prolonged cough, wheezing, sputum production. Other:
- Gastro-intestinal (Stomach & Intestines) ❑ No Problems. Heartburn, constipation, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools. Other:
- Genito-urinary (Kidney & Bladder) ❑ No Problems. Painful urination, frequent urination, urgency, prostate problems, bladder problems. Other:
- Musculoskeletal (Muscles, Bones, Joints) ❑ No Problems. Muscle aches, muscle weakness, arthritic joint pains, joint swelling, back pain. Other:
- Neurologic (Brain & Nerves) ❑ No Problems. Dizziness, lightheadedness, feeling faint, passing out, frequent headaches, blurred vision. Other:
- Psychiatric (Mood & Thinking) ❑ No Problems. Insomnia, irritability, depression, anxiety, mood swings, excessive anxiety. Other:
- Hematologic (Blood/Lymph) ❑ No Problems. Easy bleeding, easy bruising, anemia, swollen glands. Other:

Personal History:
Currently smoking: [ ] Yes [ ] Quit ___ years ago [ ] Never smoked.
Do you have a physically active lifestyle? [ ] No [ ] Yes - [ ] Exercise ____ times a week for ____ minutes
Do you follow a healthy, low saturated fat diet? [ ] No [ ] Try to [ ] Yes, most of the time.
Do you work? [ ] Yes, full-time [ ] Yes Part-time [ ] Unemployed [ ] No [ ] Retired
Do you have a hobby? [ ] No [ ] Yes – what _____
Do you have depression? [ ] No [ ] Rarely [ ] Occasionally [ ] Yes [ ] I do not know.
Stress level at work? 1—2—3—4—5—6—7—8—9—10 At home? 1—2—3—4—5—6—7—8—9--10
Do you consider your personal life happy and content? Rate 1 to 10: 1—2—3—4—5—6—7—8—9—10
Do you know your risk for heart attack and stroke in the next 10 years? [ ] Yes [ ] No
Do you want to maintain good cardiac and brain health for as long as possible? [ ] Yes [ ] No
Allergy or serious side effects from medications? [ ] No [ ] Yes – name of med and symptoms experienced:

Past Medical History:

High blood pressure [ ] No [ ] Yes	High cholesterol [ ] No [ ] Yes	Diabetes [ ] No [ ] Yes
Heart attack [ ] No [ ] Yes	Angina [ ] No [ ] Yes	Stent [ ] No [ ] Yes
Heart bypass [ ] No [ ] Yes	Stroke or TIA [ ] No [ ] Yes	GERD or ulcer [ ] No [ ] Yes

Did you have any of the tests listed below?
Coronary Calcium Score test: [ ] Yes [ ] No Date:
Nuclear stress test: [ ] Yes [ ] No Date:
2D-Echo: [ ] Yes [ ] No Date:
Holter Monitor: [ ] Yes [ ] No Date:
Cardiac cath: __ No __ Yes Date:
Recent blood tests – lipid profile, metabolic profile, etc. [ ] Yes [ ] No
List other medical problems, hospitalizations, operations and procedures: Use additional patient note page if needed.

Family Medical History:
Heart disease in father or brother before age 55? [ ] No [ ] Yes After age 55? [ ] No [ ] Yes
Heart disease in mother or sister before age 65? [ ] No [ ] Yes After age 55? [ ] No [ ] Yes

Stroke? [ ] father [ ] mother [ ] brother/sister [ ] children [ ] grandparents/uncles/aunts [ ] None
High blood pressure? [ ] father [ ] mother [ ] brother/sister [ ] children [ ] grandparents/uncles/aunts [ ] None

Diabetes? [ ] father [ ] mother [ ] brother/sister [ ] children [ ] grandparents/uncles/aunts [ ] None
High cholesterol? [ ] father [ ] mother [ ] brother/sister [ ] children [ ] grandparents/uncles/aunts [ ] None
Cancer? [ ] father [ ] mother [ ] brother/sister [ ] children [ ] grandparents/uncles/aunts [ ] None

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Patient's Additional Notes and List of Current Medications – names, dosages and frequency.

Doctor’s Notes: