Aurora Denver Cardiology Associates

Patient Name_____ Date of Service_____/_____/_____

Review of Systems-New Patient

(*Please circle any problems you have been having*)

Cardiovascular: ___No Problems

chest pain , arm pain with exertion , chest fluttering or palpitations , sleeping with more than one pillow , syncope , edema

Respiratory: ___No Problems

shortness of breath , shortness of breath with activity , shortness of breath when lying flat , cough , wheezing

Constitutional: ___No Problems

fever , night sweats , weight gain (___lbs) , weight loss (___ lbs) , fatigue

Gastrointestinal: ___No Problems

abdominal pain , vomiting , change in appetite , frequent diarrhea , vomiting blood , heartburn , nausea , constipation

ENMT: ___No Problems

Ears: difficulty hearing , ear pain **Nose:** frequent nosebleeds , nose/sinus problems

Mouth/Throat: sore throat , mouth ulcer , teeth abnormalities , snoring

Neurologic: ___No Problems

loss of consciousness , weakness , numbness , seizures , dizziness , frequent or severe headaches

Musculoskeletal: ___No Problems

muscle aches, muscle weakness , arthralgia's /joint pain , back pain , swelling in the extremities

Integumentary: ___No Problems

Skin: Jaundice , rash , itching , dry skin , growths/lesions

Hematologic/Lymphatic: ___No Problems

easy bruising , excessive bleeding , swollen glands

Psychiatric: ___No Problems

depression , sleep disturbances

Eyes: ___No Problems

dry eyes , vision change , irritation

Genitourinary: ___No Problems

difficulty urinating , blood in urine , increased urinary frequency

Reviewed All Systems With Patient Physician Signature_____

Patients Name_____ Date of Service_____/_____/_____

Primary Care Physician _____

Pharmacy Name_____**Location**_____

Allergies/Adverse Reactions_____

Social History

Smoking Status : NEVER / CURRENT/ PAST SMOKER	**Notes**	
Smoking – If so how much?	**Notes**	
Has smoked since age:_____	**Notes**	
Date Quit Smoking? _____	**Notes**	
Alcohol intake: NONE / OCCASIONAL / MODERATE / SEVERE	**Notes**	
Caffeine intake: YES OR NO	**Notes**	
Illicit drugs : _____	**Notes**	
Marital status : SINGLE / MARRIED/ DIVORCED/ WIDOWED/ SEPERATED/ OTHER_____	**Notes**	
Occupation _____	**Notes**	
Deaf or serious difficulty hearing: YES OR NO	**Notes**	
Blind or serious difficulty seeing: YES OR NO	**Notes**	
Difficulty concentrating, remembering or making decisions: YES OR NO	**Notes**	
Difficulty walking or climbing stairs: YES OR NO	**Notes**	
Difficulty dressing or bathing : YES OR NO	**Notes**	
Difficulty doing errands alone: YES OR NO	**Notes**	

Surgery:_____,_____,_____,_____

Patients Name_____ Date of Service_____/_____/_____

Past Medical History

	Y/N	Notes		Y/N	Notes
Est Pts: Any new problems since last visit?			Thyroid Disorders		
High Cholesterol			Sleep Apnea		
Myocardial Infarction			Cancer		
Stroke/TIA			Depression/Anxiety		
Hypertension			Gastrointestinal		
Diabetes			Hematologic/Lymphatic		
Aneurysm			Other		
Coronary Artery Disease			Carotid Artery Disease		
COPD/Lung Disease			Chest Pain		
Asthma/Allergies			Congestive Heart Failure		
Anemia/Bleeding Disease			Obesity		
Murmur			Peripheral Vascular Disease		
Abnormal Heart Rhythm			Pulmonary Hypertension		
Rheumatic Fever			Syncope		
Heart Burn/Peptic Ulcers/Reflux			Valvular Disease		
Autoimmune Disorders					

Family History

	Heart Disease	High blood Pressure	Stroke	Heart Attack	Cancer	High Cholesterol	Diabetes	Seizures	Pacemaker Treatment	Congenital Defects
Father										
Mother										
Brother										
Sister										

Surgery:_____,_____,_____,_____