# Cardiothoracic Intake form

DATE___________________

**LAST NAME**___________________________ **FIRST**__________________________________ **AGE**__________________

**REASON FOR APPOINTMENT**________________________**DO YOU HAVE PAIN?** ____ where _________ how long_____

**PATIENT CARE TEAM:** What providers do you see? **Referred by**: _____________________________________

Primary Care: _________________________ Cardiologist: __________________ Urologist: ___________________

Gastroenterologist: ___________________ Endocrinologist: _______________ OB/GYN: ____________________

Other: _________________________

**ALLERGIES:** ____________________________________________

**MEDICATIONS (Please list):** ___________________________________________________________________________

| **Diseases / medical problems**: | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **YES** | **NO** | **NOTES** | | **YES** | **NO** | **NOTES** |
| **DO YOU HAVE A PACEMAKER?** | | | | Glaucoma/cataracts/blindness | | | |
| Acid Reflux/GERD | | | | Headaches/Migraine Headaches | | | |
| Alcoholism | | | | Hearing Impaired | | | |
| Anemia | | | | Heart Attack | | | |
| Anxiety Disorder | | | | Heart Problems (other) | | | |
| Arthritis | | | | Hemorrhoids | | | |
| Arrhythmia | | | | Hernia | | | |
| Asthma | | | | High Blood Pressure | | | |
| Any blood relative who had anesthesia complications | | | | High Cholesterol | | | |
| Complications related to anesthesia | | | | Infection(s) | | | |
| Bleeding tendencies | | | | Kidney disease/stones | | | |
| Blood transfusion | | | | Liver Disease/Hepatitis | | | |
| Are you on blood thinners? | | | | Lumps, bumps, cysts, tumors | | | |
| Bruising | | | | Lung concerns/disease i.e. pneumonia, emphysema, bronchitis | | | |
| Cancer | | | | MRSA Infection | | | |
| Carotid Stenosis | | | | Obesity | | | |
| Chest pain | | | | Prostate concerns/disease | | | |
| Colitis | | | | PVP (Peripheral vascular disease) | | | |
| COPD/Emphysema | | | | Seizures | | | |
| Depression | | | | Shortness of Breath | | | |
| Diabetes | | | | Skin disease | | | |
| Diverticulitis | | | | Sleep apnea | | | |
| Enlarged Lymph Nodes | | | | Stroke | | | |
| Eczema | | | | Substance abuse | | | |
| Fainting | | | | Thyroid Disease/Problems | | | |
| Fatigue | | | | Vascular Concerns/Disease | | | |
| Fibromyalgia | | | | Vertigo | | | |
| Gallstones | | | | | | | |
| Genetic Mutation | | | | **OTHER:** | | | |

**SURGICAL HISTORY:** ***Please List*** _____________________________________________________________________

______________________________________________________________________________________________

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*Fax: (203)732-1525*

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**Have you had a mammogram?** where _________________________ when _________________________

**Have you had a colonoscopy?** where ___________________________ when _________________________

**FAMILY HISTORY: Please list disease (if known)** I do not know my family history _____

**Mother** _________________________ **Father** _________________________**Grandmother(M)**____________________

**Grandmother(F)**__________________ **Grandfather(M)**_________________ **Grandfather(F)** ____________________

**Sister(s)** _________________________ **Brother(s)**_________________________

## SOCIAL HISTORY (PLEASE CIRCLE AND SPECIFY)

| | | |
|---|---|---|
| **ADVANCE DIRECTIVE (PLEASE SPECIFY** | None - Do not resuscitate - Durable Power of Attorney - Living Will Healthcare Proxy | |
| **CHILDREN** | Yes No **How Many?** **Male(s)** **Female(s)** | |
| **TOBACCO USE How many packs per day?** | Never Daily Weekly Less **Former/Year Quit?**<br>**If Former – How many years?** ______ **How Much?** _______<br>**Have you ever been offered smoking cessation?** Yes No | Chewing Cigar Dip<br>E-Cig Hookah<br>Pipe Snuff Cigarette |
| **ALCOHOL INTAKE** | None Occasional Moderate Heavy **Years of Use?** | Beer Wine Liquor Other |
| **DRUG/SUBSTANCE** | Never Daily Weekly Less **Former/Year Quit?** | Pills Marijuana Cocaine Heroin Other |
| **GENERAL STRESS** | Low Medium High | |
| **DIET** | Regular / No Restrictions Diabetic Vegan Vegetarian Gluten Free Other | |
| **EXERCISE ACTIVITY** | None Occasional Moderate Heavy **#_____ Days per week** | |
| **CAFFEINE USE** | Never Daily Weekly Less **Former/Year Quit**? ______ | Chocolate Coffee Soda Tea Tablets Other: |
| **Are you sexually active** | Yes No **Do you practice Safe sex?** Yes No Sometimes | |
| **GENDER IDENTITY** | Male Female Neither exclusively Male nor female Choose not to disclose | |
| **SEXUAL ORIENTATION** | Heterosexual Gay Lesbian Bisexual Choose not to disclose | |
| **Any concerns with meeting any of the following? (If so, please specify all that apply)** | Food Housing Transportation Childcare Heating Other | |
| **Do you feel safe at home?** | Yes No | |

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