Cardio-Pulmonary Associates Medical Group

Serving the Monterey Peninsula since 1979

30 Garden Court • Monterey, CA 93940
Phone: (831) 646-8570 Fax: (831) 646-5435

Dear Patient,

The Doctors and Staff of Cardio-Pulmonary Associates Medical Group, welcome you as a new patient. Our job is to serve your medical needs in a professional, caring, and timely manner.

We have enclosed new patient information and personal history sheets. Please complete these documents and bring with you to your appointment. If you have any questions regarding these forms or your appointment, please call us at (831)646—8570.

If you are transferring to our office from another provider it is your responsibility to make sure that your Doctor's office either sends your records to us before your appointment date or gives them to you to bring to your consultation visit. Any recent diagnostic procedures lab work, etc. is helpful for us to have in your record and helps facilitate your visit with our Physician.

We look forward to seeing soon.

Cardiology:

Riaz Ahmed, M.D. **Stephen J. Brabeck, M.D.**
Nicholas K. Chee, D.O. **Michael T. Galloway, M.D.**
Thomas A. Kehl, M.D. **M. Kerala Serio, M.D.**

Interventional Cardiology:

Pir W. Shah, M.D. **Steven S. Lee, MD.**

Pulmonary:

Georgina M. Heal, M.D. **Hans P. Poggemeyer, M.D.**
John M. Koostra, M.D. **Richard J. Kanak, M.D.**

Nurse Practitioner: **Joni Hoffman, FNP**

Physician's Assistant: **Larry Rose, PA**

NAME:
AGE:
DATE:

New Patient Questionnaire

The following questionnaire will assist the Cardiologist in thoroughly evaluating your problem. Most of the questions are self-explanatory, requiring a simple circle or short answer. Please ask the receptionist if you have any questions.

Who referred you to a cardiologist? ____

What is the primary reason you are here today? __________________________________

Cardiovascular History

Cardiovascular Diagnoses: (circle all that apply)

Angina Pectoris	Congestive Heart Failure	Myocardial Infarction (heart attack)
CABG (Bypass)	Valvular Heart Disease	PTCA/Stent Placement
Arrhythmia/Pacemaker/ICD	Stroke/TIA	Peripheral Arterial Disease

List procedures/surgeries associated with above along with the dates they occurred:

1. **4.**

2. **5.**

3. **6.**

Cardiovascular Symptoms:

PLEASE REVIEW THE SYMPTOMS BELOW AND CIRCLE IF THEY APPLY TO YOU	When did this start?	When was your last episode?
pain, tightness, or discomfort in your chest or arms		
fatigue, decreased exercise capacity, reduced stamina		
palpitations, fluttering or skipped heart beats		
fainting spells or near fainting		
difficulty breathing during the day or at night		
leg swelling, edema, or discoloration		

Cardiovascular Risk Factors:

PLEASE LOOK AT THE RISK FACTORS BELOW AND COMPLETE THE CHART	Do you have these conditions? **Y/N**	If so, what year were they detected?
Hypertension (elevated blood pressure)		
Dyslipidemia (elevated cholesterol)		
Diabetes Mellitus (elevated blood sugar)		
Smoking History (tobacco use)		

General Medical History

List all medications you are currently taking. If you do not know the name of the medications you have with you, please show them to the receptionist.

(Do not omit birth control pills, diet pills, cold remedies, allergy shots, and laxatives.)

1.______________________________ 4. ______________________________

2.______________________________ 5.______________________________

3.______________________________ 6.______________________________

Are you allergic to any drugs or other agents? ☐ Y ☐ N

If yes, please list :____

HOSPITALIZATIONS

If you have been hospitalized please complete the following (other than cardiovascular procedures and childbirth):

YEAR *HOSPITAL* *REASON*

____

____

____

OUTPATIENT SURGERIES

If yes, please list below.

YEAR *LOCATION* *REASON*

Illnesses and Health Problems

PLEASE LOOK AT THE ILLNESSES AND HEALTH PROBLEMS BELOW AND CIRCLE IF THEY APPLY TO YOU	What year did you first have this condition?
Emphysema, bronchitis, pneumonia, asthma.	
Cough, wheezing, shortness of breath, blood in sputum.	
Weight loss, poor appetite, severe vomiting, hiatal hernia.	
Heart burn, stomach ulcer, diarrhea, constipation, blood in stool.	
Hepatitis, jaundice, pancreatitis, diverticulitis.	
Stroke, TIA, blindness, paralysis, numbness, weakness.	
Thyroid problem, diabetes, high blood sugar.	
Anemia, bleeding, easy bruising.	
Arthritis, joint pain, collagen vascular disease, gout.	
Fractures, disc disease, spine problems.	
Cancer (prostate, lung, etc), blood disorder (such as leukemia, myeloma, etc)	
Kidney stone, bladder infection, blood in urine.	
Skin cancer, dermatologic disorders	

Diet and Exercise

Have you gained or lost weight in the past 6 months? ☐ Y ☐ N

- If yes, please estimate how much. Gained ________lbs

  Lost ________lbs

Are you on a special diet? ☐ Y ☐ N

- If yes, please describe it. ____

Do you exercise on a regular basis? ☐ Y ☐ N

- If yes, what form of exercise? ____

Habits

Have you ever smoked cigarettes regularly? ☐ Y ☐ N

(*If yes, please complete the questions below)*

- How many packs per day at most? ________
- How long have you been (or were you) a smoker?________
- Have you quit? Y/N
  - If yes, how long ago did you quit? ________
  - If no, have you cut down? Y/N
  - If you haven't quit, how many cigarettes or packs per day do you smoke currently? _______

Do you drink beer/wine? ☐ Y ☐ N

- If yes, how many glasses per week? ____

Do you drink mixed alcoholic drinks? ☐ Y ☐ N

- If yes, how many drinks per week? ____

Family History

Has any member of your family had any of the illnesses below?

Diabetes	☐ Y	☐ N	Relationship _______
High Blood Pressure	☐ Y	☐ N	Relationship _______
High Cholesterol	☐ Y	☐ N	Relationship _______
Heart Attacks	☐ Y	☐ N	Relationship _______
Sudden Death	☐ Y	☐ N	Relationship _______
Tuberculosis	☐ Y	☐ N	Relationship _______
Bleeding Disorder	☐ Y	☐ N	Relationship _______

Is your father living? ☐ Y ☐ N If yes, list any serious illnesses: ______________________

If no, list age and cause of death: _____________________

Is your mother living? ☐ Y ☐ N If yes, list any serious illnesses: ______________________

If no, list age and cause of death: _____________________

Number of brothers and sisters living: _____

- List any serious illnesses: _____________________________________

Number of brothers and sisters deceased: ___________

- List ages and causes of death: __________________________________

Are there any other diseases which tend to occur frequently in your family? ☐ Y ☐ N

If yes, please explain: ____

THANK YOU FOR YOUR TIME IN FILLING OUT THIS QUESTIONNAIRE