

**PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT WITH DR SILVERMAN.**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PRIMARY CARE DR: \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

SUGGESTIONS:

1. IF YOUR DOCTOR'S OFFICE IS NOT LOCATED IN THE PIEDMONT PROFESSIONAL BUILDINGS, PLEASE ARRANGE WITH HIS/HER OFFICE TO PICK UP YOUR RECORDS, CHEST X-RAY AND PREVIOUS EKG'S TO BRING WITH YOU. RECORDS MAY ALSO BE FAXED TO (404) 609-6734.
2. PLEASE BRING ALL OF YOUR CURRENT MEDICATIONS IN THEIR BOTTLES AND ANY PAST MEDICAL REPORTS OR INFORMATION THAT YOU HAVE. IF YOU HAVE HAD A HEART CATHETERIZATION, PLEASE BRING REPORT.

***PRESENT PROBLEMS/CHIEF COMPLAINT:***

**CARDIOVASCULAR HISTORY:**

	YES/NO		YES/NO
RHEUMATIC FEVER	<input type="checkbox"/> <input type="checkbox"/>	CHEST DISCOMFORT/PAIN	<input type="checkbox"/> <input type="checkbox"/>
SLEEP APNEA	<input type="checkbox"/> <input type="checkbox"/>	DIZZINESS/FAINTING SPELLS	<input type="checkbox"/> <input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/> <input type="checkbox"/>	COUGH/COUGHING UP BLOOD	<input type="checkbox"/> <input type="checkbox"/>
ENLARGED HEART	<input type="checkbox"/> <input type="checkbox"/>	SWELLING OF FEET/ANKLES	<input type="checkbox"/> <input type="checkbox"/>
ABNORMAL EKG	<input type="checkbox"/> <input type="checkbox"/>	SHORTNESS OF BREATH AT REST	<input type="checkbox"/> <input type="checkbox"/>
STROKE/VASCULAR PROBLEMS	<input type="checkbox"/> <input type="checkbox"/>	SHORTNESS OF BREATH ON EXERTION	<input type="checkbox"/> <input type="checkbox"/>
HIGH LIPID LEVEL	<input type="checkbox"/> <input type="checkbox"/>	PALPITATIONS/HEART RACING	<input type="checkbox"/> <input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/>	DECREASE IN ABILITY TO DO USUAL ACTIVITY _____	<input type="checkbox"/> <input type="checkbox"/>
BLOOD CLOTS(LEGS/LUNGS)	<input type="checkbox"/> <input type="checkbox"/>		
HEART ATTACK	<input type="checkbox"/> <input type="checkbox"/>		
DATES _____			

***\*\*HAVE YOU HAD (PLEASE GIVE DATE(S) AND WHERE PROCEDURE DONE):***

ECHOCARDIOGRAM \_\_\_\_\_

OPEN HEART SURGERY \_\_\_\_\_

STRESS TEST \_\_\_\_\_

ULTRA FAST CT SCAN \_\_\_\_\_  
(ALSO CALLED EBCT)

CARDIAC CATH \_\_\_\_\_

A. ANGIOPLASTY(BALLOON) \_\_\_\_\_

B. STENT(S) \_\_\_\_\_

**\*PLEASE DESCRIBE IN DETAIL ANY CHEST DISCOMFORT(S) USING THE FOLLOWING GUIDELINES:**

- A. WHERE ON THE CHEST OR BODY DOES THE DISCOMFORT BEGIN AND WHERE DOES IT SPREAD TO?
  
- B. WHAT DOES THE DISCOMFORT FEEL LIKE (EXAMPLE: SHARP, ACHING, BURNING, CAN'T DESCRIBE, ETC.)?
  
- C. HOW LONG DOES THE DISCOMFORT USUALLY LAST AND WHAT RANGE (SHORTEST AND LONGEST) OF TIME DOES IT LAST?
  
- D. WHEN DID YOU FIRST NOTICE IT? HOW RECENTLY (PER DAY, WEEK OR MONTH) DOES THE DISCOMFORT OCCUR? IS IT INCREASING LATELY?
  
- E. WHAT SITUATIONS SEEM TO BRING ON THE DISCOMFORT (EXAMPLE: EXERCISE, EATING, EMOTION, SLEEP, POSITION, DEEP BREATHING?)
  
- F. WHAT MAKES THE DISCOMFORT WORSE AND WHAT DO YOU DO TO GAIN RELIEF FROM THE DISCOMFORT?

**\*\*PREVIOUS SURGERIES/HOSPITALIZATIONS/SERIOUS INJURIES** **WHEN**

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**\*\*MEDICATIONS (INCLUDE 'OVER THE COUNTER', EYE DROPS, HERBALS, AND VITAMINS:**

NAME	DOSAGE/FREQUENCY	NAME	DOSAGE/FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATION ALLERGIES \_\_\_\_\_

**\*\*SOCIAL HISTORY:**

MARITAL STATUS: SINGLE  MARRIED  DIVORCED  WIDOWED   
 DO YOU HAVE CHILDREN: SON(S) \_\_\_\_\_ DAUGHTER(S) \_\_\_\_\_ GRANDCHILDREN \_\_\_\_\_  
 USE OF ALCOHOL: NEVER  YES  HOW MUCH \_\_\_\_\_ HOW LONG \_\_\_\_\_  
 USE OF TOBACCO: NEVER  YES  PREVIOUSLY, BUT QUIT  CURRENT PACKS/DAY \_\_\_\_\_  
 HOW LONG \_\_\_\_\_  
 USE OF CAFFEINE: NEVER  HOW MUCH \_\_\_\_\_  
 USE OF RECREATIONAL DRUGS NEVER  RARELY  PREVIOUSLY, BUT QUIT  CURRENT   
 ANY RISK FACTORS FOR HIV? \_\_\_\_\_

**\*\*FAMILY HISTORY:**

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH AND AGE AT TIME OF DEATH
FATHER	___	_____	_____
MOTHER	___	_____	_____
SIBLINGS	___	_____	_____
	___	_____	_____
	___	_____	_____

**\*\*SYSTEM REVIEW:**

	YES/NO		YES/NO
<b>CONSTITUTIONAL SYMPTOMS</b>		<b>GASTROINTESTINAL</b>	
GOOD GENERAL HEALTH LATELY	<input type="checkbox"/>	LOSS OF APPETITE	<input type="checkbox"/>
RECENT WEIGHT CHANGE	<input type="checkbox"/>	NAUSEA OR VOMITING	<input type="checkbox"/>
FEVER	<input type="checkbox"/>	FREQUENT DIARRHEA	<input type="checkbox"/>
FATIGUE	<input type="checkbox"/>	RECTAL BLEEDING	<input type="checkbox"/>
HEADACHES	<input type="checkbox"/>	ABDOMINAL PAIN OR HEARTBURN	<input type="checkbox"/>
		PEPTIC ULCER	<input type="checkbox"/>
<b>EYES</b>			<input type="checkbox"/>
WEAR GLASSES/CONTACT LENS	<input type="checkbox"/>	HEPATITIS/JAUNDICE	<input type="checkbox"/>
BLURRED OR DOUBLE VISION	<input type="checkbox"/>	GALLBLADDER DISEASE	<input type="checkbox"/>
GLAUCOMA	<input type="checkbox"/>	PANCREATIC DISEASE	<input type="checkbox"/>
		COLON DISEASE/POLYPS/ DIVERTICULITIS	<input type="checkbox"/>
CATARACTS	<input type="checkbox"/>	HERNIA	<input type="checkbox"/>
		HEMORRHOIDS	<input type="checkbox"/>
<b>EAR/NOSE/MOUTH/THROAT</b>			<input type="checkbox"/>
HEARING LOSS OR RINGING IN EARS	<input type="checkbox"/>	<b>GENITOURINARY</b>	
VERTIGO	<input type="checkbox"/>	FREQUENT URINATION	<input type="checkbox"/>
EARACHES OR DRAINAGE	<input type="checkbox"/>	BURNING/PAINFUL/BLOODY URINATION	<input type="checkbox"/>
CHRONIC SINUS PROBLEM	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>
NOSE BLEEDS	<input type="checkbox"/>	KIDNEY STONES	<input type="checkbox"/>
SORE THROAT OR VOICE CHANGE	<input type="checkbox"/>	MENOPAUSE	<input type="checkbox"/>
PROBLEM SWALLOWING/ FOOD STICKS	<input type="checkbox"/>	IMPOTENCE	<input type="checkbox"/>
		PROSTATE DISEASE	<input type="checkbox"/>
<b>SKIN</b>		<b>HEMATOLOGIC/LYMPHATIC</b>	
RASH OR ITCHING	<input type="checkbox"/>	BLEEDING OR BRUISING TENDENCY	<input type="checkbox"/>
PSORIASIS	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>
		PAST BLOOD TRANSFUSION	<input type="checkbox"/>
<b>PULMONARY</b>		<b>NEUROLOGICAL</b>	
CHRONIC OR FREQUENT COUGH	<input type="checkbox"/>	LIGHT HEADED OR DIZZY SPELLS	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	SEIZURES	<input type="checkbox"/>
EMPHYSEMA	<input type="checkbox"/>	TREMORS	<input type="checkbox"/>
ASTHMA OR WHEEZING	<input type="checkbox"/>	PARALYSIS	<input type="checkbox"/>
SPUTUM/BLOODY	<input type="checkbox"/>	STROKE/TIA	<input type="checkbox"/>
TB/OTHER LUNG INFECTIONS	<input type="checkbox"/>	MIGRAINES	<input type="checkbox"/>
PNEUMONIA	<input type="checkbox"/>	SLEEP DISORDER	<input type="checkbox"/>
EXPOSURE TO ENVIRONMENTAL HAZARDS	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>
		MEMORY LOSS OR CONFUSION	<input type="checkbox"/>
<b>ENDOCRINE</b>			<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	NERVOUSNESS	<input type="checkbox"/>
HEAT OR COLD INTOLERANCE	<input type="checkbox"/>	INSOMNIA	<input type="checkbox"/>
THYROID DISEASE	<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>
		PANIC ATTACKS	<input type="checkbox"/>
		PSYCHIATRIC HOSPITALIZATION	<input type="checkbox"/>

FOLDER: NEW PATIENT INFO LTR FORMS ETC  
 FILE: PATIENT INFORMATION FORM.DOC