Weill Cornell Medicine

Weill Cornell Vascular

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ DOB: _____ Age: _____

Phone: (H) _____ (W) _____ (C) _____ Indicate Primary: _____

Email address: _____

Religion: _____ Ethnic Group: _____ Race: _____

Have you traveled to Africa (specifically (Guinea, Liberia , Sierra Leone, and or Mali (Kayes, Kouremale, and Bamako)? ☐ Yes ☐ No

Emergency contact: _____ Relationship: _____ Phone: _____

Primary care physician: _____ Phone: _____

Address: _____

Referring physician: _____ Phone: _____

Address: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____ Fax: _____

How did you hear about us?

☐ Referring Physician

☐ Radio ad

☐ Friend

☐ Online Research: (Circle one) cornellvascular.com NYP-Cornell website Vein Directory Yelp Facebook Vitals Healthgrades

☐ Other: (Please specify) _____

_____

I hereby assign my insurance benefits to be paid directly to NYH-CUMC Radiology Group. I am financially responsible for non-covered services. I authorize the release of medical information related to the service herein.

Signature: _____ Date: _____

Weill Cornell Vascular

New Patient Medical History Form
Pelvic Congestion

Please print clearly

Name: _____ Date: _____

Briefly explain your problem: _____

_____

_____

_____

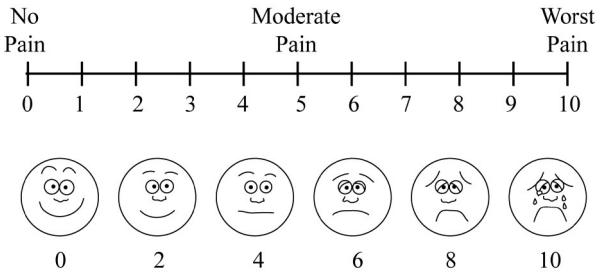
Pelvic History

Have you ever undergone any of the following treatments for pelvic pain?

	Yes	No	Date(s) performed	Outcome
Laparoscopy	☐	☐	_____	_____
Hormonal Therapy	☐	☐	_____	_____
Embolization	☐	☐	_____	_____
Other			_____	

Do you have pain with any of the following?

- ☐ Standing
- ☐ Sitting
- ☐ Lifting
- ☐ Intercourse
- ☐ Urination
- ☐ Menstrual Cycle



Do you have any of the following conditions?

- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Adenomyosis

Approximate

Date of last menstrual period: ____/____/_____

Date of last pap smear: ____/____/_____

Have you ever had abnormal pap smears?

☐ Yes ☐ No

Have you or has anyone in your family been diagnosed with "phlebitis" or "blood clots"?

☐ Yes ☐ No

If yes, detail year and treatment given. _____

Obstetrics History

Are you currently pregnant? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many children do you have? ____

Social History

Current Smoking Status:

- ☐ Current everyday smoker ____ packs/day
- ☐ Current someday smoker ____ packs/day
- ☐ Former smoker ____ packs/day
  ____ stop date
- ☐ Never a smoker
- ☐ Passive smoker

Alcohol Use:

☐ Yes ☐ No

Chewing Tobacco Use:

- ☐ Current User
- ☐ Past User
- ☐ Never a User

Past Medical History

Are you currently receiving or have you received treatment for any of the following medical conditions?

☐ Yes ☐ No

If yes, please detail below with year, diagnosis, and treatment given.

___ Anemia
___ Anxiety/Depression
___ Hiatal Hernia
___ Bleeding Disorder
___ Breast Cancer
___ Irritable Bowel Syndrome
___ Cataracts
___ Claudication
___ Diabetes
___ Gallstones
___ Heart Attack
___ Heart Murmur
___ Hemorrhoids
___ Hepatitis/Jaundice/Li
___ Sickle Cell/Carrier
___ Hypertension
___ Incontinence
___ Thrombophlebitis
___ Kidney Stones
___ Frequent Bladder Infections
___ Lung Disease
___ Migraines/Headaches
___ Mitral Valve Prolapse
___ Pneumonia/Bronchitis
___ Seizures/Epilepsy
___ Arthritis
___ Stroke
___ Cancer
(specify) _____
___ Thrombotic Disorder (Blood Clot)
___ Thyroid
___ Urinary Incontinence
___ Varicose/Spider Veins
___ Other

Details: _____

_____

Surgical History

Type of Procedure	Date of Procedure	Reason for Procedure
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Medications

Please list ALL medications (include prescription, over the counter and vitamins). If you are NOT taking any medications, please write NONE. Sign and date the form below after completion.

Medication	Dose/Frequency

Medication	Dose/Frequency

Allergies to Medications

Medication	Type of Reaction
1)	
2)	
3)	
4)	
5)	
6)	

Review of Systems

Please check any of the following that are appropriate. (If nothing is checked it is assumed negative)

Constitutional
- ☐ weight change
- ☐ fever
- ☐ chills
- ☐ night sweats
- ☐ poor appetite
- ☐ fatigue
- ☐ insomnia

Eyes
- ☐ vision change
- ☐ double vision
- ☐ pain
- ☐ discharge
- ☐ dryness

Ear, Nose and Throat
- ☐ hearing loss
- ☐ ringing in the ears
- ☐ ear pain
- ☐ ear discharge
- ☐ nasal congestion
- ☐ runny nose
- ☐ post nasal drip
- ☐ nose bleeds
- ☐ mouth ulcers
- ☐ sore throat
- ☐ dysphagia

Cardiovascular
- ☐ chest pain
- ☐ palpitations
- ☐ leg swelling
- ☐ claudication
- ☐ lightheadedness
- ☐ passing out
- ☐ decreased exercise tolerance
- ☐ heart attack

Respiratory
- ☐ shortness of breath
- ☐ cough
- ☐ coughing up blood
- ☐ wheezing
- ☐ sputum production
- ☐ snoring
- ☐ apnea
- ☐ daytime drowsiness

GI
- ☐ upset stomach
- ☐ nausea
- ☐ vomiting
- ☐ abdominal pain
- ☐ diarrhea
- ☐ constipation
- ☐ reflux
- ☐ vomiting blood
- ☐ blood in stool
- ☐ jaundice
- ☐ hepatitis

MSK
- ☐ joint aches
- ☐ muscle aches
- ☐ fractures
- ☐ bone pain

GU
- ☐ urinary frequency
- ☐ urinary urgency
- ☐ nighttime urination
- ☐ blood in urine
- ☐ pain with urination
- ☐ urinary incontinence
- ☐ urethral discharge
- ☐ genital lesions
- ☐ vaginal discharge
- ☐ vaginal bleeding

Skin
- ☐ rash
- ☐ ulcers
- ☐ hair loss
- ☐ skin changes

Neuro
- ☐ weakness
- ☐ headache
- ☐ memory loss
- ☐ convulsions
- ☐ vertigo
- ☐ tremor
- ☐ paresthesias

Endocrine
- ☐ heat intolerance
- ☐ cold intolerance
- ☐ frequent urination
- ☐ excessive thirst

Blood
- ☐ easy bleeding
- ☐ easy bruising
- ☐ enlarged lymph nodes
- ☐ anticoagulant use

Allergy/Immunology
- ☐ skin rashes
- ☐ anaphylaxis
- ☐ angioedema
- ☐ skin tightness
- ☐ morning stiffness
- ☐ Raynaud's

Psych
- ☐ depressed mood
- ☐ anxiety
- ☐ suicidal ideation
- ☐ hallucination

Additional Information

Please list any additional information that you feel is relevant

_____

_____

_____

Sign and Date Below

Please review the medications and information in this packet for accuracy and sign and date below

Patient Signature_____

Date _____