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

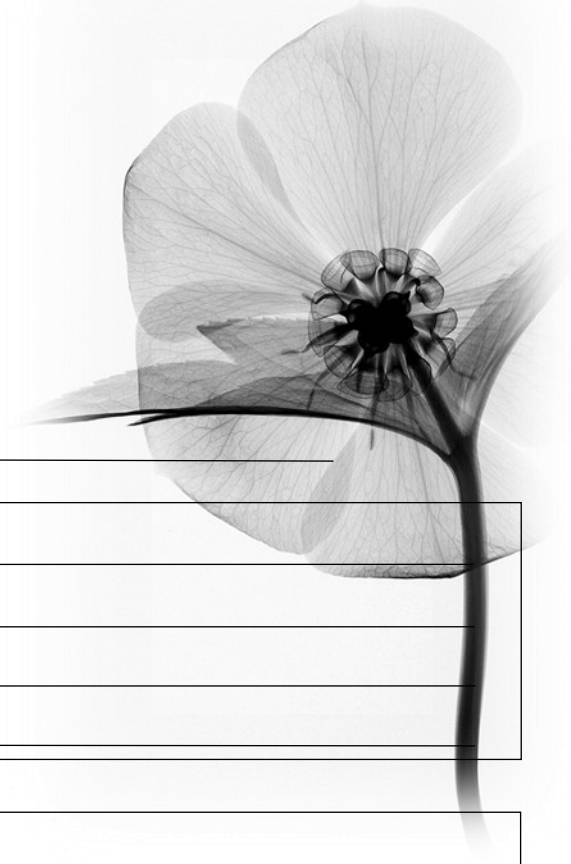
☐ Friend

☐ Online Research: (Circle one) cornellvascular.com NYP-Cornell website 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
Minimally Invasive Fibroid Treatment

Please print clearly

Name: _____ Date: _____

Briefly explain your problem: _____

_____

_____

_____

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: _____

_____

Past Surgical History

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

Obstetrics History

Total number of pregnancies: _____
Vaginal: _____
C– Sections: _____

Total number of miscarriages: _____
Total number of elective abortions: _____
Total number of ectopic pregnancies: _____

Pregnancy Complications: _____

_____

What are your plans for future pregnancies?

- ☐ Definitely in the next 2 years
- ☐ Would like to keep options available
- ☐ Definitely no further pregnancies desired

Gynecological History

When did you first find out about your fibroids? _____

Check symptoms currently related to your fibroids?

- ☐ Heavy bleeding
- ☐ Pelvic pain or pressure
- ☐ Frequent night time urination
- ☐ Constipation
- ☐ Painful intercourse

Previous treatments for fibroids:
(Provide approximate dates)

- ☐ Birth control pills _____
- ☐ Myomectomy _____
- ☐ Hysteroscopy _____
- ☐ Laparoscopy _____
- ☐ Lupron _____

Do you have any of the following conditions?

- ☐ Endometriosis
- ☐ Adenomyosis

Approximate date of last menstrual period? _____
How often does your period come? _____ days
How long does your period last? _____ days
How many days are heavy _____ days
Do you every bleed in between your periods? ☐ Yes ☐ No
Is your menstrual period unusually painful? ☐ Yes ☐ No

Are you menopausal? ☐ Yes ☐ Maybe ☐ No
If yes, age of menopause _____

Are you taking hormone replacement therapy? ☐ Yes ☐ No

Are you currently using any of the following forms of contraception?

- ☐ Birth control pills
- ☐ Tubal ligation
- ☐ IUD
- ☐ Long term injectable/ implantable

Gynecological History Continued...

Approximate date of last pap smear _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you had a recent D&C? ☐ Yes ☐ No

Have you ever had an infection in your fallopian tubes or ovaries (PID)? ☐ Yes ☐ No

If yes, year and treatment given: _____

Have you ever had any of the following gynecologic infections?

☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Syphilis ☐ Other _____

Prior Pelvic Imaging

Have you received IV contrast (dye) for a CT scan or x-ray study? ☐ Yes ☐ No

If yes, were you allergic? ☐ Yes ☐ No

Have you had an ultrasound or MRI of your fibroids?

MRI ☐ Yes ☐ No

Ultrasound ☐ Yes ☐ No

If yes, was it here at Cornell? ☐ Yes ☐ No

Family History

Does anyone in your family have fibroids? ☐ Yes ☐ No

If so, whom? _____

Does anyone in your family have a clotting or bleeding disorder? ☐ Yes ☐ No

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)	_____	_____

Additional Information

Please list any additional information that you feel is relevant

_____

_____

_____

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

Sign and Date Below

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

Patient Signature_____

Date _____