



Weill Cornell Medical College

New York-Presbyterian Hospital
Weill Cornell Medical Center

Joan and Sanford I. Weill
Medical College

1305 York Avenue, 8th Floor
New York, NY 10021
Phone: 646-962-5558
Fax: 646-962-0050

Dear New Patient,

We look forward to meeting you soon and providing you with the highest possible quality of care. We encourage our patients to actively participate in their health care and take ownership of their medical records. As such, we are providing you with a copy of a medical release form to submit to your treating physician(s) and/or hospital so that all of your relevant records can be faxed or mailed to our office in advance of your visit.

In addition, we are providing you with our intake forms to be filled out at your convenience prior to your visit. Filling these out completely and accurately will greatly improve the quality, accuracy, and efficiency of your doctor's visit.

Finally, whenever possible we prefer a written request from your referring physician for your cardiology consultation visit with us. This way we can make sure we address the right questions during your visit. We thank you for your participation and again, look forward to providing you with the highest level of care we can offer.

Sincerely,

John T. Barnard, M.D.
Assistant Professor of Medicine

William B. Borden, M.D.
Assistant Professor of Medicine

Joy M. Gelbman, M.D.
Assistant Professor of Medicine

Sarah Kaplan, M.D.
Assistant Professor of Medicine

Weill Greenberg Center Cardiology

Patient Intake Form

Name: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____ Fax # (if applicable): _____
E-mail address: _____
Alternate Address: _____

Primary Care Physician: _____
Office Address: _____
Work #: _____ Fax #: _____
Referring Physician (if different): _____
Office Address: _____
Work #: _____ Fax #: _____

Pharmacy: _____
Address: _____
Phone #: _____ Fax #: _____
Medication prescription preference (circle one): 30 day supply 90 day supply
Insurance card # (for prior authorizations, if required): _____

Would you like a translator during your visits? Yes: ___ No: ___
If yes, please list language required: _____

Why are you here to see a cardiologist today? _____

Do you currently smoke? Yes: ___ No: ___ Did you ever smoke? Yes: ___ No: ___
(If yes to either question, please indicate type of tobacco, amount per day, number of years, and quit date.)

Do you currently drink? Yes: ___ No: ___
(If yes, please indicate type(s) of alcohol and approximate number of drinks per week for each type.)

Occupation: _____ Years of education: _____

Do you have any family members with a history of:
Early heart disease (males <55 years old, females <65 years old)? Yes: ___ No: ___
Sudden unexpected death? Yes: ___ No: ___
Congenital heart disease? Yes: ___ No: ___
(e.g., hypertrophic cardiomyopathy, Tetralogy of Fallot, bicuspid aortic valve, etc.)
If yes to any of the above, please indicate relation(s) and condition(s): _____

Weill Greenberg Center Cardiology

Patient Intake Form

REVIEW OF SYSTEMS:

Please indicate if you are **currently** experiencing any of the following signs and/or symptoms:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
CONSTITUTIONAL			MUSCULOSKELETAL		
Recent change in weight?	<input type="checkbox"/>	<input type="checkbox"/>	Pains in the joints (knees, hips, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Fevers?	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pains?	<input type="checkbox"/>	<input type="checkbox"/>
Chills?	<input type="checkbox"/>	<input type="checkbox"/>	Bone fractures?	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	Pain in the bones (not joints)?	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain?	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Inability to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	Need to urinate frequently?	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Need to urinate suddenly and urgently?	<input type="checkbox"/>	<input type="checkbox"/>
Recent change in vision?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination at night (>1X)?	<input type="checkbox"/>	<input type="checkbox"/>
Double vision?	<input type="checkbox"/>	<input type="checkbox"/>	Blood in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain?	<input type="checkbox"/>	<input type="checkbox"/>	Pain while urinating?	<input type="checkbox"/>	<input type="checkbox"/>
EARS/NOSE/MOUTH/THROAT			Urinary incontinence?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>	DERMATOLOGICAL		
ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>	New rashes?	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the ears?	<input type="checkbox"/>	<input type="checkbox"/>	New ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion?	<input type="checkbox"/>	<input type="checkbox"/>	Recent hair loss?	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose?	<input type="checkbox"/>	<input type="checkbox"/>	Recent change in skin?	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip?	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINOLOGIC		
Nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>	New intolerance to heat?	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat?	<input type="checkbox"/>	<input type="checkbox"/>	New intolerance to cold?	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR			Increased frequency of urination?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains?	<input type="checkbox"/>	<input type="checkbox"/>	Increased need to drink fluids?	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations?	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL		
Inability to sleep lying flat?	<input type="checkbox"/>	<input type="checkbox"/>	New weakness?	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in the legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	New severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pains in the legs with walking?	<input type="checkbox"/>	<input type="checkbox"/>	New memory loss?	<input type="checkbox"/>	<input type="checkbox"/>
Awakening feeling short of breath?	<input type="checkbox"/>	<input type="checkbox"/>	New seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness?	<input type="checkbox"/>	<input type="checkbox"/>	Sensation of the world spinning?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGICAL		
Decreasing exercise tolerance?	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Easy bruising?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands/lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up sputum/phlegm?	<input type="checkbox"/>	<input type="checkbox"/>	Current use of warfarin/coumadin?	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC		
Wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	Diffuse itching?	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL			Anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
Nausea?	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of the throat?	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
Abdominal pains?	<input type="checkbox"/>	<input type="checkbox"/>	Depressed mood?	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	Inability to enjoy anything?	<input type="checkbox"/>	<input type="checkbox"/>
Constipation?	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/reflux?	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>
Blood in the stool?	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>

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Medical College

Department of Medicine
Division of Cardiology

1305 York Avenue
New York, NY 10021

Telephone: 646 962-5558
Fax: 646 962-0050

RELEASE OF MEDICAL RECORDS

I hereby request and authorize the Weill Greenberg Center of Cardiology,
Dr. _____, to obtain Medical information from:

Please mail or fax copies of these records to:

Fax Number: 646-962-0050

or

**Weill Greenberg Center
1305 York Ave
New York, NY 10021**

ATT: _____

Signature: _____
(If the patient is a minor, a parent or guardian must sign.)

Date: _____

Name of Patient: _____

Date of Birth: _____

Address: _____

Patient's parents' first name:

Mother: _____

Father: _____