NorthShore University HealthSystem

Cardiac & Thoracic Surgery Intake Form

Please bring this completed form to your appointment.

Name	Age	Date of Birth	Today's date

Referring Physician: ____________________

Phone # ____________________

Primary Physician: ____________________

Phone #: ____________________

Specialist: (i.e., Cardiologist, Pulmonary, Oncologist)

____

Phone #: ____________________

The Present Illness: Concern that brings you to our office

____

____

____

____

____

Your Past Medical History- include date or year of diagnosis. You may also attach a separate list.
Example: Reflux/heartburn - started 2003; had scope procedure 8/05 w/ normal result; ***please be succinct***

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Family Medical History: Any family history of cancer, stroke, blood disorders, heart disease, or any other serious medical illness?	Alive: Present Age	Deceased What Age
Mother: ____________________	________	________
Father: ____________________	________	________
Sibling: ____________________	________	________
Children: ____________________	________	________

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Surgery (major/minor procedures), when, where: (including Angioplasty)

1. ______
2. ______
3. ______
4. ______
5.

Occupation If retired prior occupation: ______

Tobacco O None O Smoked cigarettes from age _____ to _____. ____ packs per day
Check if you've used the following: O Cigars O Chewing tobacco

Alcohol O None O Estimated drinks per week ______ Preferred drink ______

Illicit Drugs O No O Yes please name: ______

Living Situation:

Marital Status: _____ single ______ married

Name of Spouse: ______

Who do you live with: ______

Do you have stairs where you live? Yes No
If yes, how many? ______

Children:

______
______
______
______

Medications (prescription & over the counter) *or attach your own list*	Dosage	Frequency	Taking for how long?

Cardiac & Thoracic Surgery ☯ 2650 Ridge Ave. 3507 Walgreen ☯ Evanston, IL 60026
(847) 570- 2868

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REVIEW OF SYSTEMS

CONSTITUTIONAL	YES	NO	CARDIOVASCULAR	YES	NO
Recent weight loss? #			High blood pressure		
Recent weight gain? #			Palpitations		
Sweats			Irregular heart beat		
Chills			Chest pain		
Fever			Exertional chest pain or pressure		
Fatigue			Shortness of breath at night		
Headache			Swelling in the legs		
Dizziness			Varicose veins		
Forgetfulness			**GI**		
Sleep disturbance			Poor appetite		
EYES			Difficulty swallowing		
Visual blurring			Nausea		
Double vision			Vomiting		
Glaucoma			Heartburn or reflux		
Cataracts			Abdominal pain		
Macular degeneration			Colon polyps		
Glasses or contacts			Bloody stool		
Ear Nose Throat			Constipation		
Sinus trouble			Diarrhea		
Decreased hearing (right/left)			Ulcer		
Deafness			Gallbladder trouble		
Hearing aids (right/left)			**GU**		
Ear pain			Nighttime urination		
Freq upper respiratory infections			Painful urination		
Persistent sore throat			Frequency		
Dental problems			Urgency		
Hoarseness			Bloody urine		
Snoring			Retention		
Sleep apnea			Incontinence		
RESPIRATORY			Kidney stone		
Cough			Urinary tract infection		
Sputum			**MUSCULO-SKELETAL**		
Bloody sputum			Back pain		
Pneumonia			Neck pain		
Asthma			Arthritis/joint pain		
Wheezing			Gout		
Shortness of breath			Muscular weakness		
Emphysema			Muscle aches, soreness		
Chronic bronchitis			**ENDOCRINE**		
NEUROLOGIC			High cholesterol		
Migraine headaches			Thyroid disorder		
Passing out			Diabetes		
Seizures			**SKIN**		
Paralysis			Rash		
Numbness or tingling			bruising		
Tremor			**PSYCHIATRIC**		
Weakness			Sleep disturbance		
Balance disturbance			Anxiety		
HEMATOLOGIC			Depression		
Anemia			Marital problems		
Bleeding disorder			Abusive relationship		
Bruising			Excessive alcohol consumption		

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