University Cardiovascular Surgeons

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

You were referred by: _____ Date: _____

Your Name: _____ Age: _____

The reason why you are here today: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Severity: _____
(How severe is the pain/problem on a scale of 1-5?)
(5 being the most severe)

Timing: _____
(Does this pain/problem occur at a specific time?)

Associated signs/symptoms: _____

_____

_____
(What other associated problems have you been having?)

Quality: _____
(Example: normal versus abnormal color, activity, etc.)

Duration: _____
(How long have you had this pain/problem?, or, When did it start?)

Context: _____
(Where were you at the onset of this pain/problem?)

Modifying factors: _____

_____

_____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Medical History:

• Patient medical history:

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis/gout	No	Yes
Convulsions	No	Yes
Bleeding tendency	No	Yes
Acute Infections	No	Yes
Venereal disease	No	Yes
Hereditary defects	No	Yes

Previous Hospitalizations/Surgeries/Serious Injuries **When?**

_____

_____

_____

_____

_____

Medications:

_____

_____

_____

_____

_____

• Patient social history:

Marital status-(circle one).	Single	Married	Separated	Divorced	Widowed	
Use of alcohol:	Never	Rarely	Moderate	Daily		
Use of tobacco:	Never	Previously, but quit: _____		Current packs/day _____		
Use of drugs:	Never	Type/Frequency: _____				
Excessive exposure at home or work to:	Fumes	Dust	Solvents	Air-borne particles	Noise	

• Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Reviewed by: _____ Date: _____

University Cardiovascular Surgeons

Patient Name: _____

CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS-NOSE-THROAT-MOUTH

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes
Chest pain or angina pectoris	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	**No**	**Yes**
Painful bowel movements or constipation.	**No**	**Yes**
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stone	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female pain with periods	No	Yes
Female irregular periods	No	Yes
Female vaginal discharge	No	Yes
Female - # of pregnancies	_____	
Female - # of miscarriages:	_____	
Female - date of last pap smear	_____	

Reviewed by: _____

Date: _____

Please indicate any personal history below.

MUSCULOSKELETAL

Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle Pain or cramps	No	Yes
Back Pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

INTEGUMENTARY (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose Veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes *(insulin or non insulin - circle one)*	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	**No**	**Yes**

HEMATOLOGIC - LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

ALLERGIC - IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptic	No	Yes

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

University Cardiovascular Surgeons
1725 W. Harrison St.
Suite 1156
Chicago, IL 60612-3824

Tel: 312.563.2762
Fax: 312.563.4388
CV_Surgery@rush.edu
www.rush.edu/ucs

RUSH UNIVERSITY
COLLEGE OF NURSING
RUSH MEDICAL COLLEGE
COLLEGE OF HEALTH SCIENCES
THE GRADUATE COLLEGE

RUSH

Walter J. McCarthy III, MD
Acting Chair

Edgar Chedrawy, MD
Marshall D. Goldin, MD
Chad E. Jacobs, MD
Robert J. March, MD
R.A. Perez-Tamayo, MD, PhD
Douglas R. Smego, MD

Professor Emeritus
Hassan Najafi, MD
Cyrus Serry, MD

Patient Communication/Learner Assessment

In order that we may better serve you , please answer the following questions.

1. When learning new information about your health, do you have any difficulty because of the following?
   - ☐ I cannot hear well
   - ☐ I cannot see well
   - ☐ I have trouble remembering things
   - ☐ I do not speak English well
   - ☐ I cannot read English well
   - ☐ No difficulties
   - ☐ Other, please specify: ______________________________
2. If there is someone needed to help you (e.g. act as interpreter), please name that person:______________________________
   If you need an interpreter, please specify the language needed: __________
3. How do you prefer to learn?
   ☐ Oral Instructions ☐ Written Instrustions ☐ Demonstrations
4. Do you have religious or cultural beliefs you want us to consider when we are planning your care?
   ☐ Yes ☐ No
5. Can we leave messages regarding your health?

At your home:	☐ Yes	☐ No	Telephone#: ______________
At work:	☐ Yes	☐ No	Telephone#: ______________
On a cell phone:	☐ Yes	☐ No	Telephone#: ______________

6. Do you prefer to communicate through electronic mail (e-mail)?
   ☐ Yes ☐ No If yes, please print your e-mail address: ______________
7. Please list the individuals that you would like to have access to your health information:
   At any time you may revoke the right you have given the individuals listed below.

First and Last Name	**Relationship**	**Please circle all that applies to each individual**
____________________	______________	1. Test results (MRI, x-ray, labs, etc.) 2. Sensitive information: (HIV and AIDS results, sexually transmitted disease results, behavioral/mental health notes) 3. Viewing of medical record 4. Billing 5. All
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In accordance with the Health Information Privacy Act passed on April 14, 2003 you must sign below to have the practices listed above take place.

______________________________ ______________________
Patient Signature Date