TCV New Patient Form

Please complete this form to the best of your ability.

Date:	☐ M ☐ F	Date of Birth:
Name:		
Address:		
Phone:	Email:	
Primary Care Physician Name:	Phone:	
Cardiologist Name:	Phone:	
Referred by Doctor:	Phone:	

DO YOU HAVE ANY OF THE FOLLOWING CARDIAC SYMPTOMS?	Yes	No
Fast or slow heart rate?		
Shortness of breath?		
Palpitations or skipped heartbeats		
Chest discomfort or pressure		
Waking up at night due to shortness of breath		
Having to prop up on pillows or sit up at night to breathe		
Swelling in ankles		
Fatigue		

WHAT IS YOUR CARDIAC HISTORY?	Yes	No
Murmur / Valvular heart disease		
Congenital heart disease (at birth)		
Arrhythmia / Atrial Fibrillation / Atrial Flutter		
Pacemaker or Defibrillator		
Syncope (passing out or fainting spells)		

DO YOU HAVE ANY ALLERGIES?

Allergy to	Type of Reaction	Severity

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Patient Name: Patient Identification #:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? *(✓ Check all that apply)*

Anemia		GER		Substance Abuse	
Anesthesia Complications		Glaucoma		Thyroid Disease	
Anxiety		Heart Attack		Tuberculosis	
Arthritis		Heart Murmur		Ulcers	
Asthma		HIV/AIDS		Blocked Carotid Arteries	
Blood Transfusion		Hyperlipidemia		Migraines	
Cancer		Hypertension		Mental Illness	
Cataracts		Kidney Disease		Poor Leg Circulation	
CHF		Meningitis		Gout	
Clotting Disorder		Nerve/Muscle Disease		Gallbladder	
COPD		Osteoporosis		Sleep Apnea	
Depression		Seizures		High Cholesterol	
Diabetes		Sickle Cell		History Rheumatic Fever	
Emphysema		Stroke			

SURGICAL HISTORY /HOSPITALIZATIONS *(✓ Check all that apply)*

Procedure	✓	Date	Procedure	✓	Date
Appendectomy			Joint Replacement		
Brain Surgery			Prostate Surgery		
CABG			Small Intestine Surgery		
Cholecystectomy			Spine Surgery		
Colon Surgery			Valve Replacement		
Cosmetic Surgery			Vasectomy		
Cosmetic Surgery			Heart Surgery		
Fracture Surgery			Lung Surgery		
Hernia Repair			Kidney Surgery		
Other:			Other:		

WHAT IS YOUR FAMILY HISTORY? *(✓ Check all that apply)* (Parents, siblings and your children)

	Age	Age of Death	Rheumatoid Arthritis	Osteo Arthritis	Cancer	Stroke	Heart Disease	High Cholesterol	Hypertension	Migraines	Seizures	Diabetes	Thyroid Disease	Liver Disease	Kidney Disease	Aneurysms	Rashes / Skin Problems
Father																	
Mother																	
Sibling(s)																	
Child(ren)																	

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WHAT ARE YOUR SOCIAL HABITS?				
Tobacco use?	☐ Yes ☐ No	☐ Current ☐ Former	Packs Per Day:	How Many Years:
Tobacco use?	☐ Yes ☐ No	☐ Current ☐ Former	Amount Per Day:	How Many Years:
Alcohol use?	☐ Yes ☐ No	☐ Current ☐ Former	Beer/Wine/Other:	Drinks Per Week:
Drug use?	☐ Yes ☐ No	☐ Current ☐ Former	Type:	Frequency:

WHAT ARE YOUR CURRENT MEDICATIONS?

Name	Dose	Frequency
Do you use oxygen?	☐ **Yes**	☐ **No**

Do you take any herbal products or non-prescription medications? *If yes, please list name, dose and frequency:*

Name	Dose	Frequency

HAVE YOU HAD ANY OF THE FOLLOWING COMPLETED RECENTLY? *If so, when and where?*

	Yes	No	When / Where
Blood / Lab work			
Cholesterol and triglyceride levels			
Blood sugar			
Stress test			
Echocardiogram (echo, heart ultrasound)			
Heart catheterization			
Holter monitor/event recorder			
Pulmonary function test (lung/breathing test)			
Vein mapping/ankle brachial index (ABI)			
Chest x-ray			
CT scan			
Any other tests or laboratory work (please list):			

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