



**CARDIO-PULMONARY ASSOCIATES
MEDICAL GROUP**

Serving the Monterey Peninsula since 1979

30 Garden Court • Monterey, CA 93940
Phone: (831) 646-8570 Fax: (831) 646-5435

Dear Patient,

The Doctors and Staff of Cardio-Pulmonary Associates Medical Group, welcome you as a new patient. Our job is to serve your medical needs in a professional, caring, and timely manner.

We have enclosed new patient information and personal history sheets. Please complete these documents and bring with you to your appointment. If you have any questions regarding these forms or your appointment, please call us at (831)646—8570.

If you are transferring to our office from another provider it is your responsibility to make sure that your Doctor's office either sends your records to us before your appointment date or gives them to you to bring to your consultation visit. Any recent diagnostic procedures lab work, etc. is helpful for us to have in your record and helps facilitate your visit with our Physician.

We look forward to seeing you soon.

Cardiology:

**Riaz Ahmed, MD
Nicholas K. Chee, DO
Thomas A. Kehl, MD**

**Stephen J. Brabeck, MD
Michael T. Galloway, MD
M. Kerala Serio, MD**

Interventional Cardiology: Pir W. Shah, MD

Steven S. Lee, MD

Nurse Practitioner: Joni Hoffman, FNP

Physician's Assistant: Larry Rose, PA

**Pulmonary: Georgina M. Heal, MD
John M. Koostra, MD**

**Hans P.O. Poggemeyer, MD
Richard J. Kanak, MD**



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NEW PATIENT QUESTIONNAIRE

Name: _____

Age: _____

Date: _____

Primary Care

Physician: _____

The following questionnaire will assist the cardiologist in thoroughly evaluating your problem. Most of the questions are self explanatory, requiring a simple circle or short answer. This form is needed only the first time you visit your cardiologist.

Who referred you to the cardiologist? _____

What is the primary problem for which you have been referred? _____

PAST MEDICAL HISTORY

Please circle any current or previous conditions that apply to you and indicate the dates of the diagnosis.

- | | | |
|--|--|---|
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> COPD/emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney stones/infection | <input type="checkbox"/> Cancer/leukemia |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Alzheimer's/dementia |
| <input type="checkbox"/> Blood clots in the legs/lungs | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> TIA | <input type="checkbox"/> GI reflux | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Carotid disease | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease | |

PAST SURGICAL HISTORY

Please circle all surgeries performed and indicate the date

- | | | |
|---|---|---|
| <input type="checkbox"/> Open heart surgery | <input type="checkbox"/> Ostomy | <input type="checkbox"/> Brain surgery |
| <input type="checkbox"/> Angioplasty/stenting | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Oral surgery |
| <input type="checkbox"/> Vascular surgery | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cataract/eye surgery |
| <input type="checkbox"/> Carotid surgery | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Pacemaker implantation | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Knee surgery | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Spine/neck surgery | <input type="checkbox"/> Breast surgery |
| | | <input type="checkbox"/> Uterus/ovaries |
| | | <input type="checkbox"/> Other: _____ |

MEDICATION LIST

Please list all medications you are currently taking. Please include all over the counter medications/vitamins/diet pills/birth control pills and any supplements.

_____	_____
_____	_____
_____	_____

ALLERGIES

Are you allergic to any drugs or other agents? ____Yes ____No If yes, please list below.

SOCIAL HISTORY

Have you ever smoked cigarettes? ____Yes ____No
If yes, how many packs per day? ____ For how many years? ____ Have you quit? ____Yes ____No ____When? ____
Do you drink alcohol? ____Yes ____No If yes, how many drinks per week? ____
What is your current occupation? ____
Are you retired? ____Yes ____No

FAMILY HISTORY

Has any member of your family had any of the conditions listed below?
Diabetes ____Yes ____No Relationship ____
High blood pressure ____Yes ____No Relationship ____
High cholesterol ____Yes ____No Relationship ____
Heart attack ____Yes ____No Relationship ____
Sudden death ____Yes ____No Relationship ____
Cancer ____Yes ____No Relationship ____
Other ____

REVIEW OF SYSTEMS

Please circle all symptoms or conditions that you are currently experiencing or have recently experienced.

GENERAL

Weight change ____Yes ____No ____Amount
Fever/chills
Fatigue all the time
Loss of appetite

EARS, NOSE, MOUTH AND THROAT

Ringing in the ears
Nosebleeds
Runny or stuffy nose
Sore throat
Difficulty swallowing
Hoarse voice

OTHER (BREASTS)

Breast lump/mass
Discharge

PSYCHIATRIC

History of depression
Anxiety or panic feelings

GENITOURINARY

Painful urination
Frequent urination
Frequent urination at night
Blood in the urine
Impotence
Vaginal discharge

Number of pregnancies
Excessive or new vaginal bleeding

HEMATOLOGICAL

Easy bleeding
Easy bruising
Swollen glands

ENDOCRINE

Hair or skin changes
Thirsty often
Weight change
Energy change

EYES

Worsening vision
Temporary loss of vision

CARDIOVASCULAR

Chest pain or pressure
Palpitations/racing heart
Irregular heart beat
waking up short of breath
Needing 2+ pillows at night
Leg cramps while walking
Swelling of the extremities
Dizziness/passing out ____

GASTROINTESTINAL

Heartburn
Stomach pains
Nausea
Vomiting
vomiting blood
Blood in bowel movement
Difficulty swallowing
Change in bowel habits
Diarrhea
Constipation
Jaundice

NEUROLOGICAL

Convulsions/seizures
passing out
Headaches
Loss of memory
Weakness on one side
Numbness/tingling

SKIN

Rash
Itching
Sores or wounds

RESPIRATORY

Shortness of breath at rest
Shortness of breath with exertion
Cough
Wheezing
Phlegm

ALLERGY/IMMUNE SYSTEM

Hives
Sneezing
Recent steroid use

MUSCULOSKELETAL

Joint/muscle swelling or pain
back or neck pain
Leg swelling
Difficulty walking on your own
Device needed to assist walking

BLOOD TRANSFUSIONS

previous history of blood transfusion
History of blood donation