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NEW PATIENT HISTORY

Date: _____ Referring MD: _____
 Patient: _____ Reason For Your Visit: _____
 DOB: ____/____/____ Age: _____ Sex: M F _____
 Medication Allergies: _____
 Pharmacy: _____ Date of Symptom(s) Onset: _____

**** SELECT YES IF YOU HAVE EVER HAD****

<u>CARDIAC PROCEDURAL HISTORY</u>		<u>VASCULAR PROCEDURAL HISTORY</u>	
1. Heart Attack If yes, when? _____	YES NO	1. Pain in calves/thighs/buttocks while walking? How far do you walk prior to pain? _____	YES NO
2. Coronary Angiogram or balloon/stent procedure? If yes, when? _____	YES NO	2. Any sores on legs/feet?	YES NO
3. Heart Surgery? If yes, type: _____ when: _____	YES NO	3. Previous surgery on arteries? (legs, abdomen, neck)	YES NO
4. Echocardiogram? (ultrasound of heart)	YES NO	4. Aneurysm? (ballooning of artery)	YES NO
		5. Carotid Doppler? (ultrasound of arteries of neck)	YES NO
		6. Arterial Doppler? (leg circulation test)	YES NO

<u>CARDIOVASCULAR RISK FACTOR SURVEY</u>			
1. Do you smoke/chew tobacco? Have you in the past?	YES NO	3. Do you have a history of Peripheral Vascular Disease?	YES NO
a. Packs/day? _____	YES NO	4. Do you have a history of high blood pressure? How long? _____	YES NO
b. Years smoked? _____		5. Do you have a history of high blood cholesterol?	YES NO
a. Packs/day? _____		6. Is there a family history of... <i>Please list relationship</i>	
2. Are you diabetic? Type 1 or Type 2? _____ How long? _____	YES NO	a. Heart Disease? _____	YES NO
		b. Diabetes? _____	YES NO
		c. Cancer? _____	YES NO
		d. Stroke? _____	YES NO

PAST MEDICAL HISTORY

Previous Surgeries and Chronic Conditions

	<u>Type</u>	<u>Date</u>
1.	History of Stroke?	YES NO
2.	Any lung disease? (COPD, Asthma)	YES NO
3.	Any GI Issues? (PUD, cirrhosis)	YES NO
4.	Any blood disorders? (anemia)	YES NO
5.	Are you on Dialysis?	YES NO
6.	History of cancer?	YES NO
7.	_____	
8.	_____	
9.	_____	
10.	_____	
11.	_____	
12.	_____	
13.	_____	
14.	_____	
15.	_____	
16.	_____	

SOCIAL HISTORY/HABITS

(Circle Selection)

Marital Status: Single Divorced Life Partner
 Married Widowed Unknown

Children: YES NO

Caffeine Status YES NO

 Types (select 2): Coffee Chocolate Tablets
 Soda Tea

Alcohol Status: Current Never Former

 Year Quit: _____

 Frequency: _____

Drug Use/Abuse Status: Current Never Former

 Year Quit: _____

 Type: _____

 Frequency: _____

 Route: _____

Primary Language: English or _____

Race: _____ or Decline

Ethnicity: _____ or Decline

REVIEW OF SYMPTOMS

(Check all that apply)

Cardiac	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Diaphoresis (<i>sweating</i>)	<input type="checkbox"/> Orthopnea (<i>difficulty breathing while laying down</i>)
	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Syncope (<i>fainting</i>)	
Vascular	<input type="checkbox"/> Claudication (<i>pain in calves / thighs / buttocks while walking</i>)	<input type="checkbox"/> Edema (<i>legs and ankles swell</i>)	
Constitutional	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fever
HEENT	<input type="checkbox"/> Visual Changes	<input type="checkbox"/> Hearing Loss	
Respiratory	<input type="checkbox"/> Snoring	<input type="checkbox"/> Hemoptysis (<i>bloody sputum</i>)	<input type="checkbox"/> Dyspnea (<i>shortness of breath with activity</i>)
Gastrointestinal	<input type="checkbox"/> Nausea	<input type="checkbox"/> Reflux	<input type="checkbox"/> Bleeding (<i>rectal bleeding / black or bloody stools</i>)
Genitourinary	<input type="checkbox"/> Hematuria (<i>blood in urine</i>)	<input type="checkbox"/> Nocturia (<i>night-time urination</i>)	
Neurological	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Seizures
Psychiatric	<input type="checkbox"/> Depression		
Hematologic	<input type="checkbox"/> Acute Anemia		
Reproductive	<input type="checkbox"/> Erectile Dysfunction		
Endocrine	<input type="checkbox"/> Goiter (<i>thyroid gland growth</i>)		
Derm	<input type="checkbox"/> Rash	<input type="checkbox"/> Skin Sores	
Musculoskeletal	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Myalgia (<i>muscle pain</i>)	