CARDIOTHORACIC SURGICAL SPECIALISTS
AMRIT P. NAYAR MD
1245 BRACE ROAD
CHERRY HILL NJ 08034
856-429-7779

PATIENT INFORMATION

HISTORY PROVIDED BY: PATIENT____ FAMILY_____ OTHER_____

DATE:_______________________

NAME:
LAST:_____________________________FIRST:____________________________INITIAL_________DOB:_________________

SOCIAL SECURITY #_____________________AGE______MALE____FEMALE____

SINGLE____MARRIED___WIDOWED___DIVORCED__

STREET ADDRESS____

____

CITY/STATE__________ZIP CODE____________

EMPLOYER____WORK TELEPHONE_______________________

SPOUSE'S
NAME____EMPLOYER______________________________________

EMERGENCY
CONTACT____TELEPHONE_______________________________________

FAMILY
DOCTOR____TELEPHONE___________________________________

ADDRESS____

____

REFERRED BY:____TELEPHONE#:_____________________________

EMAIL ADDRESS____

PATIENT REVIEW OF SYSTEMS

CIRCULATORY	YES	NO	DATE OF ONSET
CHEST PAIN			
SHORTNESS OF BREATH			
PALPITATIONS, RACING OF HEART, FAINTING			
ANKLE SWELLING/PAIN OR LEG CRAMPS			

RESPIRATORY	YES	NO	DATE OF ONSET
PNEUMONIA/BRONCHITIS			
EXCESSIVE SNORING			
TROUBLE BREATHING			
ASTHMA, WHEEZING			
COUGHING (BLOOD OR SPUTUM)			

ENDOCRINOLOGY	YES	NO	DATE OF ONSET
HARMONE PROBLEMS			
THYROID DISEASE			
DIABETES			

DIGESTIVE	YES	NO	DATE OF ONSET
HEARTBURN, HERNIA			
GALLBLADDER, LIVER			
ABDOMINAL PAIN, BOWELS			

CUTANEOUS	YES	NO	DATE OF ONSET
SKIN RASH/CANCER			

GYNECOLOGICAL	YES	NO	DATE OF ONSET
MENOPAUSE, TUMOR			
MENSTUATION,PREGNANCIES			

NEUROLOGY	YES	NO	DATE OF ONSET
CONVULSIONS, SEIZURES, HEAD INJURIES			

UROLOGY	YES	NO	DATE OF ONSET
KIDNEY, PROSTRATE			
URINARY TRACT			

MOODS	YES	NO	DATE OF ONSET
ANXIETY, PANIC			
WEIGHT CHANGE			
FATIGUE, DEPRESSION			
PSYCHIATRIC CARE			
GLAUCOMA, EARS, NOSE THROAT, CATARACTS			

JOINTS	YES	NO	DATE OF ONSET
MUSCLE, BACK, JOINT PAIN GOUT, ARTHRITIS RHEUMATISN			

HEMATOLOGY & ONCOLOGY	YES	NO	DATE OF ONSET
ANEMIA, AIDS, POSITIVE HIV			
BLEEDING OR BRUSING CANCER/TUMOR			
RADIATION TREATMENT			

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PATIENT NAME:___________________________

PAST MEDICAL HISTORY	YES	NO	WHEN/WHERE/REASON
PAST HOSPITALIZATION:	___	___	____
PAST SURGERY:	___	___	____
MEDICAL ILLNESS:	___	___	____
BLOOD WORK:	___	____	____

HAVE YOU HAVE ANY OF THE FOLLOWING:

	YES	NO	DATE		YES	NO	DATE
ECHOCARDIOGRAM	___	___	______	CARDIAC CATH	___	___	_____
HOLTER MONITOR	___	___	______	EXERCISE TEST	___	___	_____
NECLEAR STRESS	___	___	______	THALLIUM STRESS	___	___	_____
ELECTROPHYSIOLOGY STUDY	___	___	______	ARTERIAL DOPPLER	___	___	_____
ABNORMAL CHEST XRAY	___	___	______	ABDOMEN DOPPLER	___	___	_____
LUNG SURGERY	___	___	______	LOWER EXTREMITIES DOPPLER	___	___	_____

HAS A DOCTOR EVER TOLD YOU THAT YOU HAVE:

	YES	NO	DATE		YES	NO	DATE
ANGINA	___	____	______	HEART ATTACK/FAILURE	___	____	_____
ARRHYTHMIA	___	____	______	HIGH BLOOD PRESSURE	___	____	_____
RHEUMATIC FEVER	___	____	______	HIGH CHOLESTEROL	___	____	_____
CANCER (LUNG)	___	____	______	TUBERCULOSIS	____	____	_____
HEPATITIS	___	____	______				

FAMILY HISTORY

HAVE ANY BLOOD RELATIVES HAD ANY OF THE FOLLOWING:

	YES	NO	DATE		YES	NO	DATE
HEART ATTACK	___	____	______	HIGH BLOOD PRESSUSRE	___	____	_____
DIABETES	___	____	______	HEART SURGERY	____	____	_____
BLOOD DISEASE	___	____	______	ABNORMAL BLEEDING	____	_____	_____
KIDNEY DISEASE	___	____	______	CANCER	____	_____	_____
ASTHMA	____	____	______	STROKE	____	_____	_____

SOCIAL HISTORY

DO YOU SMOKE ____ ____ **HOW MANY PER DAY**_________ **HOW MANY YEARS**_____

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ALCOHOL/BEVERAGES
ESTIMATE THE AMOUNT OF ALCOHOL YOU DRINK REGULARLY: PER DAY_______ PER WEEK________

ESITMATE THE AMOUNT OF CAFFEINATED BEVERAGES: PER DAY_______ PER WEEK________

DO YOU US STREET DRUGS: YES____ NO____ LIST______________________________

DO YOU EXERCISE REGULARLY YES____ NO____ HOW MANY TIMES PER WEEK________

OCCUPATIONAL HISTORY (IF RETIRED FORMER OCCUPATION
OCCUPATION____ HOW LONG_________________________
____ __________________________________

ALLERGIES AND REACTIONS
MEDICATIONS, SHELLFISH, FOOD DYE, LATEX, IODINE, CONTRAST, NONE
LIST/EFFECTS____
____
____

CURRENT MEDICATIONS:

NAME OF MEDICATION	STRENGTH	HOW OFTEN	WHEN BEGAN TAKING

ADVANCE DIRECTIVES YES_____ NO______
COPY ON CHART YES_____NO______
PATIENT/FAMILY ADVISED TO FORWARD COPY

PATIENT RIGHTS PROVIDED YES____ NO______

PATIENT SIGNATURE____