NORTH CAROLINA HEART & VASCULAR
UNC HEALTH CARE

NEW PATIENT PAPERWORK

THIS INFORMATION IS COMPLETELY CONFIDENTIAL

Last Name _____

First Name _____

Home Phone (_____) _____ - _____

Cell Phone (_____) _____ - _____

Email _____

Date of Birth _____

Preferred Pharmacy

Name _____ Phone _____

Address

What's the reason for your visit today? What would you like to discuss?

YOUR SYMPTOMS

If you've recently had **shortness of breath**, please answer the other questions on this page. If not, skip this page.

For how long have you been experiencing shortness of breath?

What types of activities cause shortness of breath?

Do you feel short of breath when you're not doing anything?

□ *Yes* □ *No*

Does your shortness of breath worsen when you lay flat in bed?

□ *Yes* □ *No*

Do you wake up at night with shortness of breath?

□ *Yes* □ *No*

Have you noted any swelling in your face, hands, or legs?

□ *Yes* □ *No*

If you've recently had **chest discomfort**, please answer the other questions on this page. If not, skip this page.

For how long have you been experiencing chest discomfort?

How often does the discomfort occur?

In what circumstances does the discomfort occur? Is it worse with exertion?

Where is the discomfort located? Check all that apply.

□ *Left side of chest* □ *Right side of chest* □ *Middle of chest*

□ *Back* □ *Neck* □ *Arm(s)*

For how long does the discomfort typically last? _____

Which term best describes the discomfort?

□ *Pressure / heaviness* □ *Stabbing/sharp* □ *Aching*

Does it get worse when you take a deep breath? □ *Yes* □ *No*

Does it get worse in certain positions? □ *Yes* □ *No*

Does anything else make the discomfort better or worse?

On a scale of 1 to 10, where 10 is worst, how bad is it at worst? _____

If you've recently had **palpitations** (heart racing / skipping / pounding), please answer the other questions on this page. If not, skip this page.

For how long have you been experiencing palpitations?

How often do the palpitations occur?

Does anything seem to make the palpitations start or stop?

Where do you feel the palpitations? Check all that apply.

□ *Left side of chest* □ *Right side of chest* □ *Neck*

□ *Other* _____

For how long do the palpitations typically last?

Do any other symptoms accompany the palpitations? Check all that apply.

□ *Lightheadedness* □ *Shortness of breath*

□ *Chest pain/discomfort* □ *Loss of consciousness*

Please check any other symptoms you've had in the last few weeks.

□ *Fever*	□ *Chills*	□ *Cough*
□ *Headache*	□ *Weakness*	□ *Loss of consciousness*
□ *Vision change*	□ *Joint pain*	□ *Rash*
□ *Vomiting*	□ *Diarrhea*	□ *Belly pain*
□ *Bleeding/bruising*	□ *Swelling in legs/feet*	□ *Cramping/pain in legs*

If you have had any other symptom not listed above, please describe it here:

BACKGROUND AND LIFESTYLE

Employment Status

□ *Employed* □ *Retired* □ *Disabled (reason: _____)*

Occupation _____

Exercise

Do you engage in any regular exercise? □ *Yes* □ *No*

Have you noticed any recent change in your fitness level or stamina? □ *Yes* □ *No*

How many **flights** of stairs could you climb before needing to stop? _____

Describe how you stay active (including activities and minutes per week).

Do any symptoms limit your ability to exert yourself?

Diet

Do you restrict or avoid any types of food, or follow a specialized diet? If yes, describe.

How many servings of the following do you have on a typical day?

Coffee ____ *Tea* ____ *Energy Drinks* ____ *Soda* ____

Substance Use

Do you smoke? □ Yes □ Not anymore (year quit: _____) □ Never

How often do you drink alcohol?

When you drink alcohol, how many drinks do you usually consume?

Have you ever considered yourself an “alcoholic” or alcohol abuser? □ *Yes* □ *No*

In the last five years, have you used any illegal drugs? □ *Yes* □ *No*

YOUR MEDICAL HISTORY

Please check any conditions / procedures you've ever had.

□ *High blood pressure*	□ *High cholesterol*	□ *Diabetes*
□ *Heart attack*	□ *Coronary disease*	□ *Stroke*
□ *Heart failure*	□ *Stroke*	□ *Atrial fibrillation*
□ *Heart stents*	□ *Heart bypass*	□ *Ablation*
□ *Carotid blockage*	□ *Carotid stent / CEA*	□ *Leg stents*

Do you check your blood pressure at home? If so, what is the usual number?

Please list *any other* chronic medical conditions, along with the year of diagnosis.

If you've had any of these tests, please indicate the date of the most recent.

Echocardiogram (heart ultrasound) _____

Stress test _____

Event (Holter) monitor _____

Heart catheterization _____

Please list any other procedures or surgeries, including dates.

FAMILY HISTORY

Do you have parents, siblings, or children with any of the following?
If so, indicate the relation(s) and their age when the problem first occurred (if known).

□ *Heart attack* _____

□ *Stroke* _____

□ *Heart failure* _____

□ *Blood clot* _____

□ *High cholesterol* _____

□ *Diabetes* _____

□ *High blood pressure* _____

□ *Heart failure* _____

□ *Atrial fibrillation* _____

□ *Hypertrophic cardiomyopathy* _____

□ *Long QT syndrome* _____

Any other medical problems among your parents, siblings, and/or children?

Do you have biological children? If so, please list their ages and genders.

Do you have any relatives who died suddenly without explanation? If so, indicate the relation and the age of death.