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__ EMAIL ADDRESS _____________________

STREET ADDRESS____

____

CITY/STATE__________ZIP CODE____________ HOME TELEPHONE ________________ HOME CELL _______________

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			
HARMONE PROBLEMS	___	___	____________
THYROID DISEASE	___	___	____________
DIABETES	___	___	_____________

DIGESTIVE			
HEARTBURN, HERNIA	___	___	_______________
GALLBLADDER, LIVER	___	___	_______________
ABDOMINAL PAIN, BOWELS	___	___	_______________

CUTANEOUS			
SKIN RASH/CANCER	___	___	____________

GYNECOLOGICAL			
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			
ANXIETY, PANIC	___	____	_____________
WEIGHT CHANGE			
FATIGUE, DEPRESSION	___	____	_____________
PSYCHIATRIC CARE	____	____	_____________
GLAUCOMA, EARS, NOSE THROAT, CATARACTS	____	____	_____________

JOINTS			
MUSCLE, BACK, JOINT PAIN			
GOUT, ARTHRITIS RHEUMATISN	___		________________

HEMATOLOGY & ONCOLOGY			
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____