

# CARDIAC ASSOCIATES OF NORTH JERSEY, P.A.

CARDIOVASCULAR DISEASES & INTERVENTIONAL CARDIOLOGY

43 YAWPO AVENUE  
OAKLAND, NEW JERSEY 07436

WILLIAM K. LEE, M.D., F.A.C.C., F.A.C.P.  
DAVID H. MONTGOMERY, M.D., F.A.C.C.  
MARCUS L. WILLIAMS, M.D., F.A.C.C.  
NAVIN BUDHWANI, M.D.

DIPLOMATES, AMERICAN BOARD OF INTERNAL MEDICINE  
SUBSPECIALTY OF CARDIOVASCULAR DISEASES  
DIPLOMATE, INTERVENTIONAL CARDIOLOGY  
TEL: 201-337-0066 FAX: 201-337-7417

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_

## REVIEW OF SYSTEMS

Do you have a history of:      Now Prior Never      Do you have a history of:      Now Prior Never      Do you have a history of:      Now Prior Never

### SKIN

- 1. Rashes
- 2. Hives
- 3. Psoriasis
- 4. Eczema
- 5. New skin growths
- 6. Growths that change in size
- 7. A sore that does not heal
- 8. A fungus infection
- 9. Athlete's foot
- 10. Persistent itching

### EYES

- 1. Glaucoma
- 2. Cataracts
- 3. Double vision
- 4. Eye pain
- 5. Vision change

### EARS, NOSE & THROAT

- 1. Hearing loss
- 2. Ear infections
- 3. Running ears
- 4. Increasing deafness
- 5. Frequent ear pain
- 6. Hearing ringing sounds
- 7. Sinus trouble
- 8. Post-nasal drip
- 9. Frequent nose bleeds
- 10. Deviated septum
- 11. Hoarseness
- 12. Frequent sore throats
- 13. Pain on swallowing

### RESPIRATORY

- 1. Bronchitis
- 2. Asthma
- 3. Tuberculosis
- 4. Pneumonia
- 5. Chronic cough
- 6. Coughing up blood
- 7. Coughing up phlegm
- 8. Wheezing
- 9. Frequent colds
- 10. Allergy or hay fever
- 11. Chest pain
- 12. Shortness of breath
- 13. Shortness of breath with exertion
- 14. Emphysema

### CARDIOVASCULAR

- 1. Rheumatic fever
- 2. Heart murmur
- 3. High blood pressure
- 4. Treatment for blood pressure
- 5. Chest pain after eating
- 6. Chest pain with tension
- 7. Chest pain in cold weather
- 8. Chest pain after exertion
- 9. Any chest pain or tightness
- 10. Heart attack
- 11. Abnormal electrocardiogram
- 12. Rapid pulse
- 13. Irregular pulse
- 14. Fainting or dizziness
- 15. Leg cramps after walking
- 16. Leg cramps at night
- 17. Varicose veins
- 18. Swollen ankles

### GASTROINTESTINAL

- 1. Heartburn
- 2. Indigestion
- 3. Abdominal pain
- 4. Frequent constipation
- 5. Frequent diarrhea
- 6. Blood in bowel movement
- 7. Black bowel movement
- 8. Change in bowel habits
- 9. Increased appetite
- 10. Increased thirst
- 11. Decreased appetite
- 12. Frequent nausea or vomiting
- 13. Gall bladder disease
- 14. Ulcers
- 15. Intestinal polyps
- 16. Hemorrhoids
- 17. Hepatitis
- 18. Yellow eyes or skin

### GENITOURINARY

- 1. Pain when urinating
- 2. Frequent urination
- 3. Slowing of the urinary system
- 4. Sense of incomplete urination
- 5. Dribbling after urination
- 6. Blood in the urine
- 7. Sugar in the urine
- 8. Albumin in the urine

### 9. Frequent urinary tract

- infections
- 10. Kidney infection
- 11. Recurrent bladder infection
- 12. Kidney stones
- 13. Back pain
- 14. Venereal disease
- 15. Prostate infection
- 16. Pain in testicles

### MUSCULO-SKELETAL

- 1. Arthritis
- 2. Bursitis
- 3. Tendonitis
- 4. Tennis Elbow
- 5. Morning stiffness
- 6. Disc disease
- 7. Sciatica
- 8. Red or swollen joints
- 9. Gout
- 10. Back or neck pain

### NEUROLOGICAL

- 1. Frequent headaches
- 2. Migraine headaches
- 3. Blurred vision
- 4. Loss of vision
- 5. Loss of speech
- 6. Weakness in arms or legs
- 7. Numbness in extremities
- 8. Frequent dizzy spells
- 9. Convulsions
- 10. Stroke
- 11. Frequent loss of memory
- 12. Memory loss
- 13. Nervous breakdown
- 14. Balance problems

### GYNECOLOGICAL

- 1. Pregnancy
- 2. Vaginal discharge
- 3. Painful menstruation
- 4. Irregular menstruation
- 5. Female disorder treatment
- 6. At what age did you begin to menstruate? \_\_\_\_\_
- 7. What is the interval between periods? \_\_\_\_\_
- 8. What is the duration of your periods? \_\_\_\_\_
- 9. When was your last period? \_\_\_\_\_
- 10. Was the quantity normal? \_\_\_\_\_
- 11. When was your last pap smear? \_\_\_\_\_

Summary:

M.D.

# CARDIAC ASSOCIATES OF NORTH JERSEY, P.A.

CARDIOVASCULAR DISEASES & INTERVENTIONAL CARDIOLOGY

43 YAWPO AVENUE  
OAKLAND, NEW JERSEY 07436

WILLIAM K. LEE, M.D., F.A.C.C., F.A.C.P.  
DAVID H. MONTGOMERY, M.D., F.A.C.C.  
MARCUS L. WILLIAMS, M.D., F.A.C.C.  
NAVIN BUDHWANI, M.D.

DIPLOMATES, AMERICAN BOARD OF INTERNAL MEDICINE  
SUBSPECIALTY OF CARDIOVASCULAR DISEASES  
DIPLOMATE, INTERVENTIONAL CARDIOLOGY  
TEL: 201-337-0066 FAX: 201-337-7417

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

FAMILY HISTORY	Age	If Living Health	Age at Death	If Deceased Cause	Has Any Blood Relative Ever Had:	Please Encircle			
						no	or	yes	who
Father					Cancer	no		yes	
Mother					Diabetes	no		yes	
Brother or Sister	1.				Heart trouble	no		yes	
	2.				High blood				
	3.				pressure	no		yes	
	4.				Stroke	no		yes	
	5.				Epilepsy	no		yes	
	6.				Insanity				
	7.				Suicide				
	8.				Ulcer				
Husband or Wife					Gall Bladder Disease	no		yes	
Son or Daughter	1.				Thyroid trouble	no		yes	
	2.				Kidney trouble	no		yes	
	3.				Colon Polyps	no		yes	
	4.				Colitis	no		yes	
	5.								
	6.								

SURGERY: Please list

Date	Surgery
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Have you ever been advised to have any surgical operation which has not been done \_\_\_\_\_ no yes

Have you been hospitalized for any illness \_\_\_\_\_ no yes

Please list

Date	Reason
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Do you take any medications? \_\_\_\_\_ no yes

If yes, please list:

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		

## PERSONAL HISTORY

ILLNESSES: have you ever had

Please Encircle all Answers	no	or	yes
Measles _____	no		yes
German Measles _____	no		yes
Mumps _____	no		yes
Chicken Pox _____	no		yes
Whooping Cough _____	no		yes
Scarlet fever or Scarletina _____	no		yes
Diphtheria _____	no		yes
Smallpox _____	no		yes
Pneumonia _____	no		yes
Influenza _____	no		yes
Pleurisy _____	no		yes
Rheumatic fever or heart disease _____	no		yes
Arthritis or Rheumatism _____	no		yes
Any bone or joint disease _____	no		yes
Neuritis or neuralgia _____	no		yes
Bursitis, Sciatica or Lumbago _____	no		yes
Polio or Meningitis _____	no		yes
Bright's disease _____	no		yes
Gonorrhea or Syphilis _____	no		yes
Anemia _____	no		yes
Jaundice _____	no		yes
Epilepsy _____	no		yes
Migraine headaches _____	no		yes
Tuberculosis _____	no		yes
Valley fever _____	no		yes
Diabetes _____	no		yes
Cancer _____	no		yes
High or low blood pressure _____	no		yes

Nervous breakdown _____	no	yes
Food, chemical or drug poisoning _____	no	yes
Hay fever or Asthma _____	no	yes
Hives or Eczema _____	no	yes
Frequent infections or boils _____	no	yes
Frequent colds or sore throat _____	no	yes
Any other disease _____	no	yes

ALLERGIES: Are you allergic to

Penicillin or Sulfa _____	no	yes
Aspirin, Codeine, or Morphine _____	no	yes
Mycins or other Antibiotics _____	no	yes
Merthiolate or Mercurochrome _____	no	yes
Any other Drug _____	no	yes
Any Foods _____	no	yes
Adhesive Tape _____	no	yes
Nail Polish or other Cosmetics _____	no	yes
Tetanus Antitoxin or Serums _____	no	yes

INJURIES: have you had any

Broken or cracked bones _____	no	yes
Sprains _____	no	yes
Lacerations _____	no	yes
Dislocations _____	no	yes
Concussion, or head injury _____	no	yes
Ever been knocked unconscious _____	no	yes

WEIGHT: now \_\_\_\_\_, one year ago \_\_\_\_\_

Maximum \_\_\_\_\_, when \_\_\_\_\_

TRANSFUSIONS: have you ever had

Blood or Plasma transfusion _____	no	yes
-----------------------------------	----	-----

## SOCIAL HISTORY

Do you regard your work as stressful?	no	yes
Do you regard your homelife as tense?	no	yes
Do you have trouble falling asleep?	no	yes
Do you wake up often in the night?	no	yes
Do you "blow up" often?	no	yes

If you smoke cigarettes, how many per day? _____
If you smoke cigars, how many per day? _____
If you smoke a pipe, how many pipesful per day? _____
If you smoke now, or did so previously, for how many years did you smoke? _____

What is your approximate daily intake of the following?

Cups of coffee \_\_\_\_\_

Cups of tea \_\_\_\_\_

Bottles of beer \_\_\_\_\_

Glasses of wine \_\_\_\_\_