

Heart, Diabetes & Weight Loss

CENTERS OF NEW YORK

1991 Marcus Avenue, Ste. M107
Lake Success, NY 11042
Tel: (516) 222-2288

Frederic J. Vagnini, MD, FACS, FACC, FACP, FACN
Executive Medical Director

944 Park Avenue
New York, NY 10028
Tel: (212) 517-2500

Patient Registration Form

Patient Name: _____ Sex: _____ DOB: _____

Email: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Tel: _____ Work Tel: _____ SS#: _____

Employer: _____ Address: _____ City: _____ State: _____

Primary Insurance: _____ Effective Date: _____

Address: _____ City: _____ State: _____ Relationship to Pt: _____

Policy #: _____ Group #: _____ Co-Pay: _____

Insured Last Name: _____ First Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Tel: _____ Work Tel: _____ SS#: _____

Employer: _____ Address: _____ City: _____ State: _____

Secondary Insurance: _____ Effective Date: _____

Policy #: _____ Group #: _____ Co-Pay: _____

Insured Last Name: _____ First Name: _____ DOB: _____

Assignment of Benefits: I authorize that my insurance benefits be paid directly to Dr. Frederic Vagnini and acknowledge that I am financially responsible for any unpaid balance. I also authorize Dr. Frederic Vagnini to release any information required. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION.

Patient or Representative Date: _____ Reviewed By: _____

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Patient Information

Test Results

After completing your evaluation and tests, please schedule a follow-up appointment to review and outline test results and therapy. YOU WILL NOT BE CALLED WITH THE RESULTS. All test results, including blood results, will NOT be given over the telephone, unless there are special circumstances.

Follow-Ups

Following your cardiovascular evaluation, Dr. Vagnini always recommends the following studies for all patients:

- Colonoscopy (men and women)
- Urology evaluation for prostate (men)
- Breast exam and mammography (women)
- Bone density test (women)
- GYN exam (women)
- Ophthalmologic and podiatric evaluation for diabetes
- Dental evaluation (men and women)
- Coronary CT scan when indicated (men and women)

Because of the overwhelming number of calls received at the centers, some calls are lost in the voice mail system and are not received.

If your call has not been answered in a timely manner, please use alternative communication or come into our office.

24 Hour Answering Service: 1-888-320-0297

Office Fax: 516-745-0976

E-Mail: (Dr. Vagnini) fvagnini@vagnini.com

There is a 24-hour cancellation policy for doctor visits and nutritional consultations.
If the office is not notified, you will be charged.

Website: www.vagnini.com • Email: fvagnini@vagnini.com

Vascular laboratory Accredited by ICAVL

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Patient History

DATE: _____

PATIENT NAME: _____ DOB: _____ AGE: _____

REASON FOR CONSULTING WELLNESS CENTER: _____

HOSPITALIZATION & SURGERY: _____

CURRENT MEDICATIONS DOSAGES: _____

FAMILY HISTORY:

- Mother & Father: _____
- Grandparents: _____
- Siblings: _____
- Aunts & Uncles: _____

- Kidney Disease: _____
- Tuberculosis: _____
- Thyroid Disease: _____
- Anemia: _____
- Arthritis: _____
- Bleeding Disorders: _____
- Elevated Cholesterol: _____
- Cancer: _____
- Auto-Immune Diseases: _____
- Psychiatric Disorder: _____

FAMILY HISTORY OF: *(Signify relationship to patient)*

- Hypertension: _____
- Diabetes: _____
- Arteriosclerosis: _____
- Heart Attack: _____
- Stroke: _____

SOCIAL HISTORY:

Marital Status: _____ Birth Place: _____

Foreign Travels: _____

Caffeine: _____

Illicit Drugs: _____

Tobacco: _____

Past History of Tobacco Use: _____

Alcohol: _____

Dietary Restrictions: _____

Allergies: _____



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Fall Prevention, Balance & Dizziness Survey

Patient Name: _____ DOB: _____ Date: _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem, though, is to talk with your physician who might recommend that you get further testing to determine the cause of your symptoms.

CHECK (✓) ALL THAT APPLY

Please read each question and check the box that most describes your answer.	Often	Sometimes	Never
1. Do you ever lose your balance or feel dizzy or unsteady?			
2. Have you continued to experience dizziness after an injury or accident ?			
3. Do you feel unsteady when you are walking, climbing stairs?			
4. Do you feel dizzy while sitting down or rising from a seated or lying position?			
5. Does walking down the aisle of a supermarket or stopping next to moving traffic make you dizzy?			
6. Does moving your head quickly make you dizzy?			
7. Are you dizzy or unsteady when you first get up?			
8. Do you ever fall or feel like you are about to fall?			
9. Have you fallen more than once in the past year?			
10. Does dizziness or imbalance interfere with your job or your household responsibilities?			

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Review of System

PATIENT NAME: _____

DATE: _____

Please check abnormal or positive symptoms and explain in space provided at end of history section.

1. GENERAL

- weakness _____
- fatigue _____
- chills _____
- fever _____
- night sweats _____
- appetite _____
- sleeping problems _____
- anxiety attacks _____
- depression _____
- phobias _____
- food intolerance _____

2. SKIN/INTEGUMENT

- pruritus (itching) _____
- rashes _____
- skin lesions _____
- nevus _____
- infections _____
- tumors _____
- change in color _____
- texture _____
- hair loss _____
- thinning hair _____
- nails _____
- fungal infections _____
- eczema _____
- psoriasis _____
- open wounds _____
- ulcerations _____
- _____

3. BLOOD/HEMATOPOIETIC

- anemia _____
- abnormal bleeding _____
- adenopathy _____
- clotting disorders _____
- excessive bruising _____
- bleeding gums _____
- nose bleeds _____

4. CENTRAL NERVOUS SYSTEM

- headache _____
- dizzy spells _____
- light-headedness _____
- convulsions _____
- blacking out _____
- TIA _____
- stroke _____
- loss of vision 1 eye _____
- paralysis _____
- weakness, arm/leg _____
- numbness, hand/feet/face _____
- tremor _____
- loss of balance _____
- memory loss _____
- ringing ears _____
- speech disturbance _____
- visual disturbance _____
- double vision _____
- blurred vision _____

5. EARS

- ringing in ears _____
- loss of hearing _____
- infection _____
- discharge _____
- ruptured ear drum _____

6. EYES

- eyesight _____
- corrective lenses _____
- blind spots _____
- pain _____
- excessive tearing _____
- cataract _____
- glaucoma _____
- double vision _____
- blurred vision _____
- night blindness _____
- date of last eye exam _____

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Review of System *page 2*

PATIENT NAME: _____ DATE: _____

Please check abnormal or positive symptoms and explain in space provided at end of history section.

7. NOSE, THROAT AND SINUSES

- nosebleeds _____
- discharge _____
- sinusitis _____
- loss of voice _____
- hoarseness _____
- loss of smell _____
- frequent sore throats _____
- _____

8. TEETH

- cavities/caries _____
- pyorrhea _____
- extractions _____
- dentures _____
- difficulty chewing _____
- bleeding gums _____
- last dental exam _____

9. BREAST

- masses _____
- discharges _____
- pain _____
- erosions _____
- skin changes _____

10. RESPIRATORY

- cough _____
- duration _____
- amount and characteristic of sputum production:

- wheezing _____
- asthma _____
- coughing up blood _____
- recurrent infection _____
- tuberculosis _____
- pneumonia _____
- chronic bronchitis _____

11. CARDIAC

- chest pain _____
- angina _____
- history of heart attack _____
- hypertension _____
- coronary bypass surgery _____
- coronary angioplasty _____
- shortness of breath _____
- arrhythmia _____
- palpitations _____
- rheumatic fever _____
- pain in the throat of exertion _____
- ankle adema _____
- sleep on more than two pillows _____
- heart angiogram _____
- cardiac vascular problems _____
- congenital heart disease _____
- mitral valve prolapse _____
- awakened by shortness of breath _____

12. PERIPHERAL VASCULAR

- pain in legs after walking _____
- calf/thigh/buttock _____
- distance before pain _____
- pain _____
- leg cramps _____
- tightness in legs _____
- varicose veins _____
- coldness hands/feet _____
- numbness hands/feet _____
- heaviness in legs _____
- leg ulcer _____
- thrombophlebitis _____
- raynaud's _____
- discoloration hands/feet _____
- weakness arms/legs _____
- neuropathy _____
- arthritis _____

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Review of System *page 3*

PATIENT NAME: _____

DATE: _____

Please check abnormal or positive symptoms and explain in space provided at end of history section.

13. GASTROINTESTINAL

- nausea _____
- vomiting _____
- diarrhea _____
- constipation _____
- vomiting blood _____
- rectal bleeding _____
- melena _____
- change in bowel habits _____
- hemorrhoids _____
- difficulty swallowing _____
- food intolerance _____
- excessive gas or indigestion _____

- abnormal pain _____
- hepatitis _____
- hiatus hernia _____
- jaundice _____
- pancreatitis _____
- use of laxatives or antacids _____

- ulcer disease _____
- candida _____
- abdominal surgery _____
- colon cancer _____
- diverticulitis _____
- gall stones _____
- gall bladder surgery _____

14. URINARY TRACT

- pain in urination _____
- blood in urine _____
- excessive urination _____
- waking up at night _____
- incontinence _____
- kidney or bladder stones _____
- kidney infection _____
- enlarged prostate _____
- prostate cancer _____
- elevated PSA _____
- last prostate exam _____

15. MUSCULOSKELETAL

- joint pain _____
- edema _____
- heat _____
- rubor _____
- stiffness _____
- deformity _____
- myalgia _____
- weakness _____
- bone fractures _____
- gout _____
- arthritis _____
- neck problems _____
- lower back disorder _____

16. ENDOCRINE

- thyroid disease _____
- goiter _____
- heat or cold intolerance _____
- change in voice _____
- diabetes _____
- frequent or excessive urination _____
- loss or thinning of hair _____
- inability to lose weight _____
- chronic fatigue _____
- low blood sugar _____
- excessive body hair _____
- low immunity _____

17. PSYCHIATRIC

- anxiety attacks _____
- depression _____
- insomnia _____
- history of psychiatric disorder _____
- anti-depressant medications _____
- psychotropic drugs _____
- convulsions _____

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Dizziness & Balance Survey

Patient Name: _____ DOB: _____ Date: _____

(ICD-9 codes appear in italics next to the relevant item.)

Section A

- | | YES | NO |
|---|------------------------------|--------------------------|
| 1. Do you have difficulty getting up from a chair or out of bed?
(For instance: It takes more than one try to get up.) | <input type="checkbox"/> (3) | <input type="checkbox"/> |
| 2. Do you experience a numbness or loss of sensation in your legs? | <input type="checkbox"/> (4) | <input type="checkbox"/> |
| 3. Do you have trouble walking up or down inclined surfaces? | <input type="checkbox"/> (2) | <input type="checkbox"/> |
| 4. Do you ever lose your balance when standing still? | <input type="checkbox"/> (3) | <input type="checkbox"/> |
| 5. Do you feel the need to look for support or grab on to something when you are moving around? | <input type="checkbox"/> (3) | <input type="checkbox"/> |
| 6. Do you have problems judging distances when walking?
(For example: Do you feel unsure about stepping off a curb?) | <input type="checkbox"/> (3) | <input type="checkbox"/> |
| 7. Do you use an assistive device (cane, walker) to walk around? | <input type="checkbox"/> (4) | <input type="checkbox"/> |
| 8. Have you fallen more than once in the last year? | <input type="checkbox"/> (3) | <input type="checkbox"/> |
| 9. Do you ever feel unsteady or lose your balance when walking? | <input type="checkbox"/> (3) | <input type="checkbox"/> |
| 10. Do you currently take more than two (2) prescription medications? | <input type="checkbox"/> (2) | <input type="checkbox"/> |

Section B

- | | YES | NO |
|--|------------------------------|---------------------------------|
| 11. Do you feel dizzy or light-headed? | <input type="checkbox"/> (6) | <input type="checkbox"/> 780.4 |
| 12. Have you ever suffered a stroke? | <input type="checkbox"/> (4) | <input type="checkbox"/> 991.02 |
| 13. Have you ever suffered any type of head or neck trauma?
(For example: Auto accident, sports injury, work-related injury.) | <input type="checkbox"/> (4) | <input type="checkbox"/> 716.18 |
| 14. Do objects appear to bounce or jump around? | <input type="checkbox"/> (6) | <input type="checkbox"/> 368.10 |

VESTIBULAR ASSESSMENT SCALE

Total from Section A: _____

Total from Section B: _____ ÷ 2

Fall Risk Score (A+[B/2]): _____

Fall Risk Scoring Key *Note: Any positive response on their questionnaire may indicate that the patient is at risk for falls.*

Score	Indication
4-7	The patient is at increased risk for falls. Schedule examination with physician.
8 or greater	The patient has a high probability for falling. Physical examination and therapy should be scheduled as soon as possible

Dizziness & Balance Survey

Section C

	YES	NO
15. If you experience dizziness, do you notice a spinning sensation when dizzy?	<input type="checkbox"/> (3)	<input type="checkbox"/> 386.10
16. If you experience dizziness, do sudden changes in position (such as bending down, tilting your head, quickly turning) make your symptoms worse?	<input type="checkbox"/> (4)	<input type="checkbox"/>
17. Have you noticed a decrease in hearing?	<input type="checkbox"/> (2)	<input type="checkbox"/> 389.9
18. Do you experience vision problems such as double vision or blurred vision?	<input type="checkbox"/> (3)	<input type="checkbox"/> 368.2/368.8
19. Do you have an increased sensitivity to light and/or sound?	<input type="checkbox"/> (3)	<input type="checkbox"/> 368.9/388.40
20. Do you experience dizziness when turning over in bed?	<input type="checkbox"/> (4)	<input type="checkbox"/>
21. Do you experience dizziness when watching a moving object?	<input type="checkbox"/> (4)	<input type="checkbox"/>
22. If you have dizziness, do you feel pain or pressure in your ears during an attack?	<input type="checkbox"/> (3)	<input type="checkbox"/> 388.8
23. Have you ever been knocked unconscious?	<input type="checkbox"/> (2)	<input type="checkbox"/>
24. Do you experience frequent headaches or migraines?	<input type="checkbox"/> (4)	<input type="checkbox"/> 346.90
25. Does looking up or down cause you to become dizzy?	<input type="checkbox"/> (4)	<input type="checkbox"/>
26. Do you experience a ringing, buzzing or other sound in your ear(s)?	<input type="checkbox"/> (2)	<input type="checkbox"/> 388.30

VESTIBULAR ASSESSMENT SCALE

Total from Section B: _____

Total from Section C: _____

VNG Necessity Score (C+B): _____

VNG Scoring Key

Overall Score Indication

0-4 Need for VNG / ENG not indicated.

5-9 Possible need for VNG / ENG assessment. Patient should be scheduled for examination with physician to determine necessity for evaluation.

10 or greater Strong need for VNG / ENG assessment. Patient should be referred for evaluation.

Indications for Specific Pathology

Benign Paroxysmal Positional Vertigo: total of (15)_____+(16)_____+(20)_____+(25)_____ = _____386.11
>10 = increased likelihood of BPPV

Meniere's Disease: total of (15)_____+(17)_____+(22)_____+(26)_____ = _____386.00
>5 = increased likelihood of Meniere's Disease

Vestibular Migraines: total of (13)_____+(18)_____+(19)_____+(24)_____+(26)_____ = _____346.90
>8 = increased likelihood of vestibular migraines