CARDIOVASCULAR ASSOCIATES

1600 Stewart Avenue · Westbury, NY 11590
Phone: 516-222-2288 · Fax: 516-745-0976

944 Park Avenue · New York, NY 10028
Phone: 212-517-2500

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

PATIENT REGISTRATION FORM

Patient Name____________________ **Sex**______ **Date of Birth** ________

Email____________________ **Age**______________

Address________________ **City**__________ **State**_____ **Zip**_____

Home Phone #____________ **Work #** ____________**SS #**__________

Employer__________ **Address**____________ **City**_______ **State**_____

Primary Insurance Carrier__________________ **Effective Date**__________

Address____________ **City**________ **State**_____ **Relationship to pt.**_______

Policy No.______________**Group No.**______________ **Co-Pay**_______

Insured Last Name______________ **First Name**________ **D.O.B.**__________

Address________________ **City**__________ **State**_____ **Zip**_____

Home Phone #____________ **Work #** ____________**SS #**__________

Employer__________ **Address**____________ **City**_______ **State**_____

Secondary Insurance Carrier__________________ **Effective Date**__________

Policy No.______________**Group No.**______________ **Co-Pay**_______

Insured Last Name______________ **First Name**________ **D.O.B.**__________

Assignment of benefits I authorize that me insurance benefits be paid directly to Dr. Frederic Vagnini and acknowledge that I am financially responsible for any unpaid balance. Please remember that payment is your obligation. 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.

____________________________ Date ________ Reviewed By _______
(Patient or Representative)

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PATIENT INFORMATION

Because of the overwhelming number of calls received at the Centers, frequently 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
E-mail (Dan) info@vagnini.com
E-mail (Jen) jen@vagnini.com

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, are not given over the phone, unless there are special circumstances.

FOLLOW-UPS. Following your cardiovascular evaluation, Dr. Vagnini always recommends the following studies on 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 diabetics
Dental evaluating (men and women)
Coronary CT scan when indicated (men and women)

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

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CARDIOVASCULAR & STROKE RISK ANALYSIS

If you check any of these, you may be at risk of:
Arteriosclerosis, Stroke, Aneurysm, Heart Attack,
Peripheral Arterial Disease, Diabetic Disease

GENERAL

- ☐ Smoking
- ☐ Overweight
- ☐ Sedentary
- ☐ Stress
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ High LDL
- ☐ Low LDL
- ☐ Family history of
  - ☐ Arterio sclerosis
  - ☐ Stroke
  - ☐ Heart attack
  - ☐ Aneurysm
  - ☐ Diabetes
- ☐ Thyroid Problems

Previous Positive Vascular Testing

CEREBRO-VASCULAR

- ☐ Fainting or Blacking Out
- ☐ Dizzy Spells
- ☐ Ringing in Ears
- ☐ Balance Loss
- ☐ Visual Disturbance
- ☐ Speech Difficulty
- ☐ Numbness in Face, Arm or Leg
- ☐ Memory Loss
- ☐ Light-headedness
- ☐ Headaches
- ☐ Hearing-Loss
- ☐ Transient Vision Loss in One Eye
- ☐ Double Vision
- ☐ Previous Stroke
- ☐ TIA
- ☐ Carotid Surgery
- ☐ Family History of Stroke
- ☐ Carotid Bruit

CARDIAC

- ☐ Chest Pain
- ☐ Angina
- ☐ Previous Heart Attack
- ☐ Irregular Heart Beat
- ☐ Shortness of Breath
- ☐ Rheumatic Fever
- ☐ Pain in Throat
- ☐ Pain Down Arms
- ☐ Fainting
- ☐ Swelling of Ankles
- ☐ Difficulty Lying Flat
- ☐ Light-headedness

PERIPHERAL VASCULAR

- ☐ Leg Pain After Walking
- ☐ Leg Pain at Rest
- ☐ Leg Cramps
- ☐ Coldness of Feet
- ☐ Numb or Tingling Feet
- ☐ Heaviness of Legs
- ☐ Leg Ulcer
- ☐ Toe Discoloration
- ☐ Recurrent Toe Infection
- ☐ Swelling of Ankles
- ☐ Varicose Veins
- ☐ History of Thrombo-Phlrbltis
- ☐ Diabetic Neuropathy
- ☐ Post Vascular Surgery
- ☐ Raynaud's Disease
- ☐ Numb or Tingling Hands
- ☐ Cramps in Fingers

SCORING:

Some of the above are absolute major risk finding and suggest you should definitely seek a comprehensive arteriosclerosis evaluation. Others are minor indications and put you at lower risk. If you would like to discuss your findings, please call.

(516) 222-2288

URL: http://www.vagnini.com · e-mail: fvagnini@pb.net

Vascular Laboratory Accredited by ICAVL

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Patient History

Patient Name: ______________________________ Date: ____________ Age: ________
Date of Birth: ______________

REASON FOR CONSULTING WELLNESS CENTER:

____
____
____

HOSPITALIZATION & SURGERY:

____
____
____

CURRENT MEDICATIONS DOSAGES:

____
____
____

FAMILY HISTORY:

- ☐ Mother & Father: ______________________
- ☐ Grandparents: ______________________
- ☐ Siblings: ______________________
- ☐ Aunts & Uncles: ______________________

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

____

- ☐ Hypertension: ______________________
- ☐ Diabetes: ______________________
- ☐ Arteriosclerosis: ______________________
- ☐ Heart Attack: ______________________
- ☐ Stroke: ______________________
- ☐ Kidney Disease: ______________________
- ☐ Tuberculosis: ______________________
- ☐ Thyroid Disease: ______________________
- ☐ Anemia: ______________________
- ☐ Arthritis: ______________________
- ☐ Bleeding Disorders: ______________________
- ☐ Elevated Cholesterol: ______________________
- ☐ Cancer: ______________________
- ☐ Auto-Immune Diseases: ______________________
- ☐ Psychiatric Disorder: ______________________

____
____

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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____

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Patient Name: ______________________________ Date: ____________

REVIEW OF SYSTEM: (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. 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. 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 in one 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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Patient Name: ______________________________ Date: ______________

REVIEW OF SYSTEM: (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:

- ☐ 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: ______________
- ☐ thrombophlabitis: ______________
- ☐ raynaud's: ______________
- ☐ discoloration hands/feet: ______________

____

- ☐ weakness arms/legs: ______________
- ☐ neuropathy: ______________
- ☐ arthritis: ______________

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13. GASTROINTESTINAL:

- ☐ nausea: ______________________________
- ☐ vomiting: ______________________________
- ☐ diarrhea: ______________________________
- ☐ constipation: ______________________________
- ☐ vomiting blood: ______________________________
- ☐ rectal bleeding: ______________________________
- ☐ melena: ______________________________
- ☐ change in bowl 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. MUSCULOSKELTAL:

- ☐ joint pain: ______________________________
- ☐ edema: ______________________________
- ☐ heat: ______________________________
- ☐ rubor: ______________________________
- ☐ stiffness: ______________________________
- ☐ deformity: ______________________________
- ☐ myalglas: ______________________________
- ☐ weakness: ______________________________
- ☐ bone fractures: ______________________________
- ☐ gout: ______________________________
- ☐ arthritis: ______________________________
- ☐ neck problems: ______________________________
- ☐ low 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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