Consultants in Cardiology, P.A.

Diplomates American Board of Internal Medicine
Cardiovascular Disease

Interventional and Non-Invasive Cardiology
Preventative Cardiology
Jacqueline M. Schwanwede, MD, FACC
Mark C. Goldberg, MD, FACC
Edward R. Harback, MD, FACC

Nicholas G. Tullo, MD, FACC, FHRS
Cardiac Electrophysiology
Jeffrey S. Lander, MD, FACC
Non-Invasive and Sports Cardiology

Physician Assisstant
Leigh C. Mosquera, PA-C

Nurse Practitioner
Amanda Scelfo, AGPCNP-BC
Jessica N. Walsh, DNP, NP-C

Dear Patient:

Thank you for choosing Consultants in Cardiology. We look forward to meeting you on _____ at _____. We Would like you to have some information about our office procedures before you arrive.

Your first visit will take approximately one hour in our office. You **must** arrive 20 minutes prior to your scheduled appointment time with the enclosed forms **fully completed**, or your appointment may be delayed and/or rescheduled. The office asks that you please do not mail or fax this packet to us, bring it with you on the day of your visit completed.

You may take all your medications on the day of your visit. **PLEASE BRING A LIST OF YOUR CURRENT MEDICATIONS. THIS IS VERY IMPORTANT FOR A PROPER EVALUATION.**

Copies of any medical records concerning your condition should be brought in with you for your physician. Please make a copy for the office, any additional copies made by the office staff will be charged $1.00 per page.

Please bring your insurance cards and photo identification. If you are unable to keep your scheduled appointment, please notify the office within 24 hours to avoid a no show fee.

If you have any questions, please do not hesitate to contact our office in advance of your visit.

Thank you.

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Zabrina Laqui, MSN, APN-C
Amanda Scelfo, AGPCNP-BC

DIRECTIONS TO OUR OFFICE

FROM ROUTE 10 EAST: Go to the Livingston traffic circle and take Northfield Avenue through 4 lights. Keep left for 3/10 of a mile and turn left onto driveway that reads 741-743 Northfield Office Center.

FROM ROUTE 287 (NORTH OR SOUTH): Exit at Route 10 East. Follow directions above.

FROM GARDEN STATE PARKWAY (NORTH OR SOUTH): Go to Exit #145 (Route 280 WEST) to Exit 10 (Northfield Avenue). At light at the top of the ramp, turn left onto Northfield Avenue. Stay straight on Northfield Avenue for approximately 4 miles. Turn right onto the driveway that reads 741-743 Northfield Office Center.

FROM NEW JERSEY TURNPIKE (NORTH OR SOUTH): Take Exit #15W to Route 280 WEST to Exit 10 (Northfield Avenue). At light at the top of the ramp, turn left onto Northfield Avenue. Stay straight on Northfield Avenue for approximately 4 miles. Turn right onto the driveway that reads 741-743 Northfield Office Center.

FROM ROUTE 80 EAST: Exit 280 East to Exit #6 (LAUREL AVENUE). Make a right onto Laurel Avenue. At fork in the road stay left and continue for several miles to Northfield Avenue. (EXXON STATION ON THE LEFT). Turn left onto Northfield Avenue. Keep left for 3/10 of a mile and turn left onto driveway that reads 741-743 Northfield Office Center.

FROM ROUTE 78 (EAST AND WEST): Exit at Route 24 WEST. Continue to JFK Parkway, following signs to Livingston. Turn right onto Northfield Avenue. Proceed through one traffic light. Keep left for 3/10 of a mile and turn left into driveway that reads 741-743 Northfield Office Center.

ICANL Nuclear Cardiology
Accredited Nuclear Cardiology Laboratory

West Orange Office
741 Northfield Avenue • Suite 205 • West Orange, NJ 07052 • www.heartdocsnj.com
Phone: (973) 467-1544 • Fax: (973) 467-9586
Outpatient Testing
Phone: (973) 467-8955 • Fax: (973) 467-1172

ICAEL

Consultants in Cardiology

Initial Evaluation Form

Name:_____ Age_____ Date of Birth _____

Marital Status: _____ Spouse's Name: _____

Your Occupation: _____ Employer: _____

Who referred you? _____

Primary Physician: _____ Cardiologist: _____

What is the reason for this visit? _____

_____

Do you have any of the following symptoms?			
	Yes	No	How Long?
Palpitations (Funny heart beats)			
Tachycardia (Racing heart beats)			
Lightheadedness / dizziness			
Fainting (passing out)			
Weakness			
Fatigue			
Chest Pain			
Shortness of breath at rest			
Shortness of breath with activity			
Shortness of breath lying flat			
Waking up at night short of breath			
Weight gain			
Weight loss			
Leg pain with walking			
Swelling / edema			

Past Medical History			
	Yes	No	When?
Heart rhythm problem			
Coronary blockages			
Heart attack			
Heart failure			
Heart murmur			
Heart valve problem			
Rheumatic fever			
Mitral valve prolapse			
High blood pressure			
Diabetes			
High cholesterol			
Stroke / TIA			
Peripheral vascular disease			
Lung disease			
Kidney disease			
Stomach / colon disease			
Blood problems			

Habits

Did you ever smoke? _____

If so, how much? _____

When did you quit smoking? _____

How much alcohol do you drink? _____

Were you ever a heavy drinker? _____

How much caffeine do you consume? _____

Are you on any special diet? _____

How much do you exercise? _____

Did you ever use street drugs? _____

For Doctor's Use

PLEASE TURN THE PAGE TO CONTINUE THIS FORM

Consultants in Cardiology – Initial Evaluation Form

Patient Name: _____

Hospitalizations / Major Illnesses	Date

Past Surgery	Date

Medications
(Include vitamins and over-the-counter pills)

Name	Dose	Times per day

Family History

	Mother	Father	Siblings	Grand-parents
Heart arrhythmia				
High blood pressure				
Diabetes				
High cholesterol				
Coronary disease				
Heart attack				
Sudden death				
Stroke				
Fainting				
Kidney disease				
Other				

Are your parents still living?

List Medication Allergies:	

Are You Allergic To:	Yes	No
X-Ray Contrast, Iodine, or Shellfish?		
Latex?		

For Doctor's Use

PLEASE TURN THE PAGE TO CONTINUE THIS FORM

Consultants in Cardiology – Initial Evaluation Form

Patient Name: _____

Review Of Systems

Do you have any of the following symptoms?		Yes	No
General	Unexplained fevers		
	Weight loss		
	Weight gain		
HEENT	Eyeglasses		
	Cataracts / contact lenses		
	Glaucoma		
	Sinus problems		
	Nose bleeds		
	Gum problems		
	Unrepaired tooth problems		
Resp	Emphysema		
	Bronchitis		
	Asthma		
	Cough		
	Wheezing		
	Coughing up blood		
GI	Nausea / vomiting		
	Diarrhea		
	Constipation		
	Bloody stools		
	Abdominal pain		
	Frequent belching		
	Stomach ulcers		
	Acid reflux		
	Indigestion		
GU	Kidney stones		
	Painful urination		
	Blood in urine		
	Frequent urinary infections		
	Impotence / sexual problems		

Do you have any of the following symptoms?		Yes	No
MS	Joint pains / arthritis		
	Muscle pains or cramps		
	Muscle weakness		
	Back pain		
	Cold hands / fingers		
	Cold feet		
	Blue fingers		
Skin	Rash		
	Itching		
	Varicose veins		
Neuro	Headaches		
	Numbness / tingling		
	Weakness on one side		
	Tremor / shaking		
	Difficulty speaking		
	History of head injury		
Psych	Depression		
	Anxiety		
	Insomnia		
Endo	Thyroid problems		
	Heat intolerance		
	Cold intolerance		
	Other glandular problems		
Heme	Bleeding		
	Easy bruising		
	Anemia		
	History of blood transfusion		
	HIV / AIDS		

_____ Patient signature

_____ Physician Signature