NAPLES HEART RHYTHM SPECIALISTS, P.A.
PROVIDING COMPREHENSIVE CARDIOLOGY SERVICES
ELECTROPHYSIOLOGY · CARDIOLOGY · CARDIAC IMAGING · CARDIAC PET

## Patient Information Sheet

Patient's First Name: _____ Middle Initial: _____ Last Name: _____
Street Address: _____ City: _____ State/Zip: _____
Local Phone No: (  )_____ Email Address: _____
Emergency Phone No: (  )_____ DOB:_____ Sex ☐Female ☐Male
Marital Status: ☐ Married ☐Divorced ☐Singled ☐Widowed SSN:_____
Primary Provider:_____ Referring Physician: _____
Cell Phone No : (  )_____

**Employer Information**

Employers Name: _____
Employers Address: _____ City:_____State/Zip:_____
Employers Phone No: (  ) _____

**Primary Insurance Information**

Primary InsuranceCarrier:_____EffectiveDate:_____
Group No:_____ Policy No:_____
Relationship to subscriber:_____(If relationship is self-DO NOT fill in Subscriber's Information)
Subscriber's Frist Name: _____ Middle Initial: _____ Last Name:_____
Subscriber's Address:_____City:_____State/Zip:_____
Subscriber's DOB:_____ Sex☐ Female ☐ Male SSN:_____
Copay/Deductible :_____

**Secondary Insurance Information**

Secondary InsuranceCarrier:_____EffectiveDate:_____
Group No:_____ Policy No:_____
Relationship to subscriber:_____(If relationship is self-DO NOT fill in Subscriber's Information)
Subscriber's Frist Name: _____ Middle Initial: _____ Last Name:_____
Subscriber's Address:_____City:_____State/Zip:_____
Subscriber's DOB:_____ Sex☐ Female ☐ Male SSN:_____
Copay/Deductible :_____

**Out of State Information**

Out of State Street Address:_____ City:_____
State:_____ Zip Code:_____Phone Number: (  )_____


**ELECTROPHYSIOLOGY SERVICES**
PHYSICIANS REGIONAL MEDICAL CENTER
6101 Pine Ridge Rd Desk 12
NAPLES, FL 34119
OFFICE: 239.263.0849

**CARDIAC IMAGING & CARDIAC PET CENTER**
THE BRENNAN BUILDING
730 GOODLETTE RD N. SUITE 100
NAPLES, FL 34102
OFFICE: 239.682.6603
WWW.NAPLESCARDIACPET.COM

# Naples Heart Rhythm Specialists

Patient Name: _____ DOB: _____ Date: _____

Are you allergic to any medications? ☐ NO ☐ YES Please list: _____

## Past Medical History

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Diabetes | ☐ | ☐ | Osteoporosis | ☐ | ☐ | Blood Clots |
| ☐ | ☐ | Chest Pain/Angina | ☐ | ☐ | Asthma/COPD | ☐ | ☐ | Peripheral Vascular Disease |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stroke/CVA/TIA | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Seizures | ☐ | ☐ | Depression |
| ☐ | ☐ | Heart Attack | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Congestive Heart Failure |
| ☐ | ☐ | High Cholesterol | ☐ | ☐ | Hepatitis | ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Pacemaker/ICD | ☐ | ☐ | Stomach Ulcer | ☐ | ☐ | Other (Please list below) |
| ☐ | ☐ | Headaches | ☐ | ☐ | Liver Disease | | | |
| ☐ | ☐ | Kidney Stones | ☐ | ☐ | Heart Palpitations | | | |
| ☐ | ☐ | Kidney Disease | ☐ | ☐ | Arthritis | | | |
| ☐ | ☐ | Cancer | ☐ | ☐ | Heart Surgery | | | |

## Current Medications

1
2
3
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11
12

## Review of System (-) Please check all CURRENT positive findings

| | | |
|---|---|---|
| Constitutional | ☐ | ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats ☐ Weight loss |
| Eyes | ☐ | ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision ☐ Blurry vision |
| ENT | ☐ | ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐ Sore throat |
| Cardiovascular | ☐ | ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet ☐ Chest pain |
| Respiratory | ☐ | ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐ Shortness of breath |
| Gastrointestinal | ☐ | ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐ Nausea |
| Genitourinary | ☐ | ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ Frequent UTIs ☐ Increased urinary frequency |
| Skin | ☐ | ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐ Rash |
| Musculoskeletal | ☐ | ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain ☐ Joint pain |
| Endocrine | ☐ | ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excess sweating ☐ Goiter |
| Neurological | ☐ | ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐ Seizures |
| Hem/Lymphatic | ☐ | ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots ☐ Low blood count |
| Allerg/Immun | ☐ | ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐ Allergic reactions |

## Social History:

Marital Status: _____ Occupation (or most recent job held): _____ Retired ☐

☐ Non-Smoker (never smoked) ☐ Ex-Smoker Quit: _____ ☐ Current Smoker How many packs/day? _____

Alcohol consumption: _____ drinks/day drinks/week Caffeine consumption: _____ drinks/day drinks/week

## Family History: (Please list any known medical problems)

Father: _____ Age: _____ Mother: _____ Age: _____

Any Siblings: _____

Your children: _____

Have you ever fainted suddenly and unexpectedly during exercise? YES NO

Any sudden and unexpected deaths in your family members who were less than 50 years of age? YES NO

## Additional Information: Use this space to provide any additional information which may be important to your health care.

Height: _____ Weight: _____

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date

# NAPLES HEART RHYTHM SPECIALISTS, P.A.

Breast Cancer, Pregnancy, and Breast Feeding Verification Form

Must be completed by **ALL** patients.

Patient Name: _____ Date of Birth: _____

Have you ever had any radiation to your chest? Yes No

**Females:**

Are you postmenopausal? Yes No

Have you had a hysterectomy, tubal ligation, etc? Yes No

Are you premenopausal? Yes No

When was your last menstrual cycle? Date: _____

Could you be pregnant? Yes No

Are you currently breastfeeding? Yes No

Have you had a mastectomy? Yes No

Left Right Both

Have you or do you currently have breast implants? Yes No

Left Right Both

Have you had any other type of breast surgery? Yes No

Please specify: _____

Do you have a history of Fibrocystic breast disease? Yes No

Breast/Bra Cup Size: _____

**Males:**

Have you ever been diagnosed with Breast Cancer? Yes No

Have you ever been diagnosed with gynecomastia (male breasts)? Yes No

Patient Signature: _____ Date: _____