epiccardiology

Please answer all of the questions below. Do not worry if you are unsure or cannot remember some of answers. **Please do not leave blanks.** If you are not sure, or do not understand a question, just insert a question mark.

PATIENT INFORMATION

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETE FOR ALL PATIENTS:

Name

_____

Last *First* *M.I.*

Date of Birth: ____ /____ /____ Age: _____ Sex: ☐ Male ☐ Female

Social Security No _____ Driver's License No _____

ADDRESS:

Mailing Address _____

City *State* *Zip*

Home Phone: ( ) _____ Work Phone: (_____

Cell Phone: ( ) _____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: ____ /____ /____

Last *First* *M.I.*

Address: _____

City *State* *Zip*

Home Phone: ( ) _____ Work Phone: ( ) _____

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Date: ____ /____ /____ Signature: _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form.

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Today's Date ____ /____ /____

Other family members who are patients _____

Referred by: _____

Primary Care Physician _____ Phone ( ) _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? _____ Phone ( ) _____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?

☐ **YES** ☐ **NO** If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (_____) _____ Phone # (evening): (_____) _____

May we leave personal medical information on your answering machine or cell phone?
☐ **YES** ☐ **NO**

May we e-mail personal medical information to you? ☐ **YES** ☐ **NO**

E-mail address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have receiver and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ Date ____ /____ /____

DATE _____ PATIENT'S NAME _____

HOSPITALIZATION & SURGICAL HISTORY *List in chronological order:*

Reason for Hospitalization	Hospital & City	Date(s)

Surgeries and/or Procedures	Hospital & City	Date(s)

CURRENT MEDICATIONS: *List medicines, dose (e.g. milligrams) and how often taking:*

Medicine	Dose	How Often	Date Started

PATIENT SIGNATURE _____

DATE _____ PATIENT'S NAME _____

DRUG ALLERGIES / INTOLERANCES

Medicine	Reaction

FAMILY HEALTH HISTORY

Relation	Age if Alive	Age at death	**Major Illnesses or cause of death** (e.g. blood pressure heart attack, diabetes, alcoholism, cancer, seizures, etc.)
Mother			
Father			
Brothers			
and			
Sisters			
Spouse			
Children:			

SOCIAL HISTORY AND HABITS

Marital Status: _____ Married _____Single

Children: _____ Yes, how many _____ _____ No

Occupation: _____

Number of Alcoholic Drinks: _____ Per day _____ Per week, year quit_____

Tobacco History

❒ None

❒ Yes

❒ Cigarettes: Current _____, _____packs per day Former _____ year quit _____

❒ Cigars: Current _____, _____packs per day Former _____ year quit _____

❒ Chewing Tobacco: Current _____, _____packs per day Former _____ year quit _____

Illicit/IV Drug abuse: ❒ none ❒ active ❒ former

PATIENT SIGNATURE _____

DATE:_____ **PATIENT'S NAME:**_____

REVIEW OF SYSTEMS:

Answer all questions! If you are not sure, or do not understand the question, insert a question mark. Please leave no blanks.

CONSTITUTIONAL	**YES**	**NO**	**GENITOURINARY**	**YES**	**NO**
Fever	☐	☐	Urinary Loss of Control	☐	☐
Night Sweats	☐	☐	Difficulty Urinating	☐	☐
Weight Gain (___Lbs.)/Months	☐	☐	Increased Urinary Frequency	☐	☐
Weight Loss (___Lbs.)/Months	☐	☐	Hematuria	☐	☐
Exercise Intolerance	☐	☐	Incomplete Emptying	☐	☐
EYES	**YES**	**NO**	**MUSCULOSKELETAL**	**YES**	**NO**
Dry Eyes	☐	☐	Muscle Aches	☐	☐
Irritation	☐	☐	Muscle Weakness	☐	☐
Vision Change	☐	☐	Arthralgias/ Joint Pain	☐	☐
EMNT	**YES**	**NO**	Back Pain	☐	☐
Difficulty Hearing	☐	☐	**INTEGUMENTARY**	**YES**	**NO**
Ear Pain	☐	☐	Abnormal Moles	☐	☐
Frequent Nosebleeds	☐	☐	Jaundice	☐	☐
Nose/Sinus Problems	☐	☐	Rash	☐	☐
Sore Throat	☐	☐	Itching	☐	☐
Bleeding Gums	☐	☐	Dry Skin	☐	☐
Snoring	☐	☐	Growths/ Lesions	☐	☐
Dry Mouth	☐	☐	**NEUROLOGIC**	**YES**	**NO**
Oral Abnormalities	☐	☐	Loss of Consciousness	☐	☐
Mouth Ulcer	☐	☐	Weakness	☐	☐
Teeth Abnormalities	☐	☐	Numbness	☐	☐
Mouth Breathing	☐	☐	Seizures	☐	☐
CARDIOVASCULAR	**YES**	**NO**	Dizziness	☐	☐
Chest Pain	☐	☐	Frequent or Severe Headaches	☐	☐
Chest Pain on Exertion	☐	☐	Migraines	☐	☐
Arm Pain on Exertion	☐	☐	Restless Legs	☐	☐
Shortness of Breath When Walking	☐	☐	**PSYCHIATRIC**	**YES**	**NO**
Shortness of Breath When Lying Down	☐	☐	Anxiety	☐	☐
Palpitations	☐	☐	Depression	☐	☐
Known Heart Murmur	☐	☐	Sleep Disturbances	☐	☐
Light-Headed On Standing	☐	☐	Restless Sleep	☐	☐
Swelling in the Extremities	☐	☐	Feeling Unsafe In a Relationship	☐	☐
RESPIRATORY	**YES**	**NO**	Alcohol Abuse	☐	☐
Cough	☐	☐	**ENDOCRINE**	**YES**	**NO**
Wheezing	☐	☐	Fatigue	☐	☐
Shortness of Breath	☐	☐	Increased Thirst	☐	☐
Coughing Up Blood	☐	☐	Hair Loss	☐	☐
Sleep Apnea	☐	☐	Increased Hair Growth	☐	☐
GASTROINTESTINAL	**YES**	**NO**	Cold Intolerance	☐	☐
Abdominal Pain	☐	☐	**HEMATOLOGIC/ LYMPHATIC**	**YES**	**NO**
Heartburn	☐	☐	Swollen Glands	☐	☐
Vomiting	☐	☐	Easy Bruising	☐	☐
Change in Appetite	☐	☐	Excessive Bleeding	☐	☐
Bright Blood per Rectum	☐	☐	**ALLERGIC/ IMMUNOLOGIC**	**YES**	**NO**
Black or Tarry Stools	☐	☐	Runny Nose	☐	☐
Constipation	☐	☐	Sinus Pressure	☐	☐
Frequent Diarrhea	☐	☐	Itching	☐	☐
Vomiting Blood	☐	☐	Hives	☐	☐
	☐	☐	Frequent Sneezing	☐	☐