For Office Use Only
Verified Date: _____
By: _____
System Account#: _____

How did you hear about HeartPlace?
❑ Physician Referral ❑ Advertisement
❑ Friend ❑ Other: _____ Date: _____

Patient Information

Name: _____ Doctor: _____
last first middle

Social Security #: _____ Email Address: _____

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

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

❑ Married ❑ Single ❑ Widow ❑ Divorced Age: _____ Date of Birth: _____ ❑ Male ❑ Female

Employer Name: _____ Employer Address: _____

❑ Full-Time ❑ Part-Time ❑ Retired ❑ Self-Employed ❑ Student Full-Time ❑ Student Part-Time

Referring Physician: _____ Referring Physician Ph.: (____) _____

Primary Care Physician: _____ Primary Care Physician Ph.: (____) _____

Insured Name (If no insurance, responsible party)

Name: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

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

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

Employer Name: _____ Employer Address: _____

Notify In Case of Emergency

1. Name: _____ Relationship: _____ Ph.#: _____ Wk.#: _____

2. Name: _____ Relationship: _____ Ph.#: _____ Wk.#: _____

Insurance Information – Copies of Insurance Cards and Drivers License are Required

Insurance 1: _____

Address: _____ Ph.#: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Insurance 2: _____

Address: _____ Ph.#: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Authorizations

For and in consideration of the services rendered by HeartPlace, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgements obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign HeartPlace all rights, title and interest in any payment due me for services described herein as provided in the above-mentioned policies of insurance/settlements or judgements. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Patient Signature: _____ Date: _____

Patient Name (Please Print): _____

Witness Signature: _____ Date: _____

HEARTPLACE PATIENT PRIVACY NOTICE SUMMARY

Protecting your confidential health information is important to us. Certain federal law referred to as "**HIPAA**" protects the confidentiality of your health information (generally referred to as "**Protected Health Information**" or "**PHI**"), and we take it seriously. This summary of our **Notice of Privacy Practices** ("**Notice"** or **"Privacy Notice")** has been prepared to provide you with a brief description of certain of the key provisions of the Notice regarding how medical and other personal information about you may be used or disclosed, and how you may obtain access to your information and its disclosure. For a more complete description of our privacy practices under HIPAA, please refer to the attached Notice.

What is Protected Health Information (PHI)?

PHI is information created or received by HeartPlace and transmitted or maintained in written, electronic or any other form, that relates to your past, present or future health condition, the provision of healthcare to you, and/or information about payment for the provision of your healthcare, and, which may identify you or could reasonably be used to identify you.

How may my PHI be used or disclosed?

HeartPlace may use or disclose your PHI to carry out your **'Treatment'** (provision, coordination or management of your healthcare or related services), **'Payment'** (obtain payment for your healthcare services, including activities that may be required by your insurer(s) to obtain approval for payment), or for other **'Health Care Operations'** (other functions that HeartPlace performs in connection with providing health care, i.e., quality assessments, training of medical students, credentialing, auditing and financial reporting). Use or disclosure of your PHI pursuant to the Notice may include electronic transmittal or disclosure. HeartPlace also sends PHI to a Health Information Exchange (HIE) to allow for information exchange for information that may be relevant to your future care i.e. in an emergency situation participating facilities and physicians can access your information for your treatment. In addition, your prior prescription information will be obtained through SureScripts to assist us in providing you treatment. You can opt out of the HIE and of SureScripts by completing the appropriate forms available when you ask your HeartPlace office staff.

When might HeartPlace use or disclose my PHI without my authorization?

HeartPlace is not required to obtain your authorization or notify you when it uses or discloses your PHI for your treatment, to obtain payment, or for other health care operations as discussed above. In addition, there are some limited exceptions where the law allows your PHI to be used to promote the Government's need to ensure a safe and healthy society. In some cases, you may be given an opportunity to agree or object before the use or disclosure of your PHI. In all cases, HeartPlace will make every effort to ensure that it meets necessary prerequisites and will not use or disclose your PHI more than is permitted under the law.

What Are My Rights Under the HIPAA Privacy Standards?

Patients have certain rights under the HIPAA Privacy Standards, subject to certain limitations:

- You have the right to request restrictions on certain uses and disclosures of your PHI by HeartPlace.
- You have the right to request that we communicate with you in a certain way. We make every effort to honor your reasonable requests for confidential communication.
- You have the right to read, review and receive copies of your health information.
- You have the right to request and obtain an accounting of disclosures HeartPlace has made of your PHI.
- You have the right to request an amendment to your PHI. *(HeartPlace reserves the right to deny requests to amend PHI. For example, if the information is accurate, or if the information was not created or is not maintained by HeartPlace.)*
- You have the right to request a copy of the Privacy Notice.
- You have the right to file a complaint if you believe that HeartPlace has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules.

HEARTPLACE PRIVACY OFFICER

HeartPlace has procedures in place for receiving and resolving HIPAA-related complaints, and, handling other HIPAA and PHI requests and concerns. Such issues are handled by the **HeartPlace Privacy Officer**. You may:

- Request additional restrictions for release of your PHI
- Change restrictions/change contact information
- Request an amendment to your health record
- Request copies of the Notice
- Resolve your complaints *(complaints must be directed in writing to the Privacy Officer).*

Contact the HeartPlace Privacy Officer:
By Mail: HeartPlace, Attn: Privacy Officer, 16980 Dallas Parkway, Suite 200 Dallas, TX 75248
By Phone: (972) 391- 1900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the **HeartPlace Notice Privacy Practices**.

_____ _____/_____/_____
Patient Name (Print) Date of Birth

_____ _____/_____/_____
Patient Signature Date of Acknowledgement

RELEASE OF HEALTH INFORMATION

PRIMARY CARE PHYSICIAN (PCP): _____

Address of PCP: _____

❑ HeartPlace **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone, except as permitted by HIPAA and other applicable laws.

❑ HeartPlace **MAY** discuss my healthcare and **MAY** discuss and/or make financial arrangements with only the following individual immediate family members listed below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I understand that if I would like to authorize HeartPlace to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards.

_____ _____ _____/_____/_____

Patient Name (Please Print) Patient Signature Date

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.

❑ No Expiration
❑ Date of Expiration _____/_____/_____
❑ Event: (Describe event upon which this Authorization will expire) _____

PATIENT CONTACT PREFERENCES

I prefer to be contacted in the following manner:
❑ Phone #: (_____) _____ - _____
❑ OK to leave message with detailed information
❑ OK to leave message with contact number only
❑ DO NOT LEAVE MESSAGE

All normal test results will be sent via our **Patient Portal** to **Email**: (PLEASE PRINT)

_____ @ _____ . _____

Appointment reminders: ❑ Text [# if different than above (_____) _____ -_____]
❑ Phone
❑ Email

AUTHORIZATION FOR ACCESS AND USE OF SURESCRIPTS PRESCRIPTION HISTORY

HeartPlace, with your authorization, has the ability to import the last 16 months of your prescription history directly from the Surescripts E-prescribing database. Surescripts is used by most pharmacies and insurance companies to process prescriptions. If you paid cash or did not pickup a prescription, it will not be in the Surescripts database.

The import of Surescripts prescription history is not required for treatment. HeartPlace understands there may be situations, prescriptions, and medical history you do not want to share with your physician. Notifying your physician of all your medical history and currently prescribed medications is critical for proper care.

I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") by Surescripts and the access and use of that information by HeartPlace, P.A. ("HeartPlace").

Patient's Name: _____ **Date of Birth:** _____

Name of organization(s) authorized to access, use or receive the Protected Health Information: **Surescripts and HeartPlace.** Specific description of Protected Health Information to be accessed, used or disclosed: Prescription drug information, including patient medication history data, maintained in the Surescripts electronic prescription data system.

Event on which this Authorization will expire: **One year**

I understand that I may refuse to sign this Authorization, and that my health care treatment will not be conditioned upon signing this form. I also understand that my Protected Health Information is subject to redisclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace or Surescripts took before it received the revocation of this Authorization. I understand that I may see and copy the Protected Health Information described on this Authorization, if I request to do so in writing. I understand that I will receive a copy of this Authorization after I sign it.

Will HeartPlace or any of its providers receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes___ No__X_**

_____ _____
Signature of individual or individual's representative Date

_____ _____
Printed name of individual's representative Relationship to patient

_____ _____
Witness Date

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

New Patient Medical Questionnaire

DATE: _____/_____/_____

Patient Name:_____DOB:_____AGE: _____

Primary Care Physician:_____City/State: _____

Other Physicians: _____

Pharmacy:_____City/Intersection/Phone:_____

What physician requested this consultation? _____

CHIEF COMPLAINT

What problems are you here for today? _____

_____

CARDIAC PROBLEM LIST

Please check any of the following disorders that you HAVE or HAVE HAD, and indicate the year it was first identified.

CARDIAC:

☐ **Yes** ☐ **No** Cardiomegaly (Enlarged Heart) _____

☐ **Yes** ☐ **No** Heart Disease you were born with(congenital)____

☐ **Yes** ☐ **No** Rheumatic Fever _____

☐ **Yes** ☐ **No** Murmur_____

☐ **Yes** ☐ **No** Abnormal Heart Valve _____

☐ **Yes** ☐ **No** Endocarditis (infected heart valve)_____

☐ **Yes** ☐ **No** Abnormal ECG_____

☐ **Yes** ☐ **No** Angina (heart pain)_____

☐ **Yes** ☐ **No** Heart Attack _____

☐ **Yes** ☐ **No** Coronary Artery Disease _____

☐ **Yes** ☐ **No** Heart Failure / Cardiomyopathy _____

☐ **Yes** ☐ **No** Arrhythmia / Abnormal Rhythm_____

☐ **Yes** ☐ **No** Previous Cardiac Arrest _____

☐ **Yes** ☐ **No** Defibrillated / Shocked _____

☐ **Yes** ☐ **No** Pericardial(sac surrounding heart) Disease_____

☐ **Yes** ☐ **No** Marfan's Syndrome_____

☐ **Yes** ☐ **No** Hospitalized for cardiac reasons_____

☐ **Yes** ☐ **No** Other type of heart disease_____

VASCULAR:

☐ **Yes** ☐ **No** Carotid Artery Disease _____

☐ **Yes** ☐ **No** Renal(kidney) Artery Disease _____

☐ **Yes** ☐ **No** Peripheral(leg or arm) Artery Disease _____

☐ **Yes** ☐ **No** Pulmonary embolism (clots in lung) _____

☐ **Yes** ☐ **No** Varicose Veins _____

☐ **Yes** ☐ **No** Stroke or TIA (mini-stroke)_____

☐ **Yes** ☐ **No** Any history of aneurysm _____

☐ **Yes** ☐ **No** DVT (clots in leg) _____

☐ **Yes** ☐ **No** Other type of vascular Disease _____

CORONARY RISK FACTORS

☐ **Yes** ☐ **No** Hypertension (high blood pressure) _____

☐ **Yes** ☐ **No** Abnormal Cholesterol / Triglycerides_____

☐ **Yes** ☐ **No** History coronary disease in immediate family?

☐ **Yes** ☐ **No** Diabetes Mellitus _____

☐ **Yes** ☐ **No** Currently Smoking?_____

☐ **Yes** ☐ **No** Peripheral artery disease? (legs, carotids)_____

Reviewed By:_____

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ AGE: _____

CURRENT MEDICATIONS / SUPPLEMENTS ☐ Yes ☐ No

Please list ALL the medications that you are taking at home. Include ALL prescription medications, non-prescription medications, vitamins, herbal remedies and supplements.

	Name of Medication	Dose/Strength	How Many/How Often/When
Example	*Lasix*	*40 mg*	*twice a day - morning and night*
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			

(Please attach additional pages if necessary)

ALLERGIES / INTOLERANCES TO MEDICATIONS ☐ Yes ☐ No

Please list any medications, or materials you are allergic to, had an adverse reaction to, or do not tolerate and describe the reaction.

Medication	Reaction (e.g. hives, swelling, short of breath, rash, etc)

Reviewed By:_____

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ AGE: _____

CARDIAC PROCEDURES/DIAGNOSTIC TESTING ☐ Yes ☐ No

Please check that you have had or have not had any procedures / diagnostic tests. Write the year / location of the test in the blanks indicated.

			Year	Location
❑ Yes	❑ No	Echo (Heart Ultrasound)	_____	_____
❑ Yes	❑ No	Stress Test	_____	_____
❑ Yes	❑ No	Holter/Event Monitor	_____	_____
❑ Yes	❑ No	Carotid Artery Ultrasound	_____	_____
❑ Yes	❑ No	Heart Catheterization	_____	_____
❑ Yes	❑ No	Heart Angioplasty/Stent Placement	_____	_____
❑ Yes	❑ No	Peripheral Artery Angiogram (Non Heart)	_____	_____
❑ Yes	❑ No	Peripheral Artery Angioplasty (Non Heart)	_____	_____
❑ Yes	❑ No	Electrophysiology Study	_____	_____
❑ Yes	❑ No	Heart Rhythm Ablation	_____	_____
❑ Yes	❑ No	Pacemaker/ICD(defibrillator)	_____	_____
❑ Yes	❑ No	Cardiac Surgery	_____	_____

LAB WORK: Month & Year of most recent?_____ Location? _____

PAST MEDICAL HISTORY

Please check any of the following disorders that you HAVE or HAVE HAD, and indicate the year it was first identified.

PULMONARY:

☐ **Yes** ☐ **No** Asthma _____
☐ **Yes** ☐ **No** Emphysema / COPD _____
☐ **Yes** ☐ **No** Pneumonia _____
☐ **Yes** ☐ **No** Bronchitis _____
☐ **Yes** ☐ **No** Tuberculosis _____
☐ **Yes** ☐ **No** Sleep Apnea _____

GASTROINTESTINAL:

☐ **Yes** ☐ **No** Reflux(GERD)_____
☐ **Yes** ☐ **No** Diverticulosis / Diverticulitis _____
☐ **Yes** ☐ **No** Liver Disease / Hepatitis _____
☐ **Yes** ☐ **No** Gallbladder Disease / Gallstones _____
☐ **Yes** ☐ **No** Hiatal Hernia _____
☐ **Yes** ☐ **No** Ulcers _____
☐ **Yes** ☐ **No** Gastritis _____
☐ **Yes** ☐ **No** Gastrointestinal Bleed _____

RENAL / GENITOURINARY:

☐ **Yes** ☐ **No** Dialysis _____
☐ **Yes** ☐ **No** Kidney Stones _____
☐ **Yes** ☐ **No** Prostate Disease _____
☐ **Yes** ☐ **No** Kidney Disease / Elevated Creatinine _____

NEUROLOGICAL / PSYCHOLOGICAL:

☐ **Yes** ☐ **No** Intracranial (in the brain) Bleeding _____
☐ **Yes** ☐ **No** Migraine Headaches _____
☐ **Yes** ☐ **No** Depression _____
☐ **Yes** ☐ **No** Seizure Disorder _____
☐ **Yes** ☐ **No** Dementia _____
☐ **Yes** ☐ **No** Anxiety Disorder _____

Reviewed By:_____

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ AGE: _____

FEMALE REPRODUCTIVE: ☐ **Not Applicable**

☐ **Yes** ☐ **No** Multiple miscarriages_____ ☐ **Yes** ☐ **No** Currently Pregnant (number of weeks?)_____

☐ **Yes** ☐ **No** Menopause (at what age?)_____

ENDOCRINE:

☐ **Yes** ☐ **No** Thyroid Disorder _____ ☐ **Yes** ☐ **No** Adrenal Disorder _____

OTHER:

☐ **Yes** ☐ **No** Anemia _____ ☐ **Yes** ☐ **No** Bleeding Disorder _____

☐ **Yes** ☐ **No** Clotting Disorder_____ ☐ **Yes** ☐ **No** Gout _____

☐ **Yes** ☐ **No** Arthritis _____ ☐ **Yes** ☐ **No** Ambulate with assistance_____

☐ **Yes** ☐ **No** HIV_____ ☐ **Yes** ☐ **No** Previous weight Loss meds (i.e. Fen Phen) ____

☐ **Yes** ☐ **No** Reaction to iodine contrast_____ ☐ **Yes** ☐ **No** Previous exposure to iodine contrast

☐ **Yes** ☐ **No** Vertigo_____ ☐ **Yes** ☐ **No** Cancer (type?) _____

☐ **Yes** ☐ **No** Autoimmune Disorders (i.e. Lupus) _____

Please list any other health problems that are not on the list:

SURGICAL HISTORY / OPERATIONS ☐ Yes ☐ No

Please list any surgeries you have had and include the year and location.

Surgery	Date	Surgeon	Location
Example: Gallbladder Removed	*1980*	*Dr. Frank Smith*	*Parkland, Dallas*

Reviewed By:_____

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ AGE: _____

SOCIAL HISTORY

Marital Status?: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐ Previously Widowed

Number of sons?:_____ Number of daughters?:_____ Current hometown?: _____

With whom do you live? _____

Do you have a Medical Power of Attorney? ☐ Yes ☐ No Who? _____

Advanced Directives?: ☐ None ☐ **D**o **N**ot **R**esuscitate ☐ Healthcare Proxy ☐ Living Will Date: _____

Are you retired?: ☐ Yes ☐ No Current or Previous Occupation: _____

Primary language?_____ Secondary language?_____

Leisure activities?: (Include any hobbies) _____

Home exercise equipment? ☐ Yes ☐ No If yes, what types:_ _____

Home blood pressure monitor? ☐ Yes ☐ No If yes, average readings: _____

Do you use tobacco? ❑ **Yes** ❑ **Formerly** ❑ **Never**

Type:	**How much:**	**Start/Quit Dates**
☐ Cigarettes	_____per day	Years Smoked?_____ Quit Date? _____
☐ Cigars	_____per day	Years Smoked?_____ Quit Date? _____
☐ Pipes	_____per day	Years Smoked?_____ Quit Date? _____
☐ Chewing tobacco	_____per day	Years Used?_____ Quit Date? _____

Do you use alcohol? ❑ **Yes** ❑ **Formerly** ❑ **Never**

Describe your use?

☐ Rarely ☐ Social ☐ Daily ☐ Frequently ☐ Occasional ☐ Quit (when)

Type:	**How much:**
☐ Beer	_____ cans per day / wk / mo / yr
☐ Wine	_____glasses per day / wk / mo / yr
☐ Spirits	_____glasses per day / wk / mo / yr

Do you use caffeine? ☐ **Yes** ☐ **Formerly** ☐ **Never**

Type:

☐ Caffeinated Coffee?_____cups per day / wk / mo / yr ☐ Quit (when) _____

☐ Caffeinated Tea?_____cups per day / wk / mo / yr ☐ Quit (when) _____

☐ Caffeinated Soda?_____cans per day / wk / mo / yr ☐ Quit (when) _____

☐ Chocolate?_____servings per day / wk / mo / yr ☐ Quit (when) _____

Reviewed By:_____

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ AGE: _____

Do you use recreational drugs? _____ ☐ **Yes** ☐ **Formerly** ☐ **Never**

Type:	**How much:**	**Start/Quit Dates**
☐ Marijuana	_____per day/wk/mo/yr	When did your start?_____Quit?_____Rehab? _____
☐ Cocaine	_____per day/wk/mo/yr	When did your start?_____Quit?_____Rehab? _____
☐ Methamphetamine	_____per day/wk/mo/yr	When did your start?_____Quit?_____Rehab? _____
☐ Other	_____per day/wk/mo/yr	When did your start?_____Quit?_____Rehab? _____

Exercise?

☐No/Sedentary ☐Occasional ☐Regular ☐Active Lifestyle ☐Physically Unable to exercise

Type:	**How much:**	**Check any applicable:**
☐ Aerobics	How long? (Mins.)_____How often? (Per wk) _____	☐ Started Exercising
☐ Cycling	How long? (Mins.)_____How often? (Per wk) _____	
☐ Dancing	How long? (Mins.)_____How often? (Per wk) _____	
☐ Jogging	How long? (Mins.)_____How often? (Per wk) _____	
☐ Running	How long? (Mins.)_____How often? (Per wk) _____	
☐ Swimming	How long? (Mins.)_____How often? (Per wk) _____	
☐ Team sports _____	How long? (Mins.)_____How often? (Per wk) _____	
☐ Walking	How long? (Mins.)_____How often? (Per wk) _____	
☐ Weights	How long? (Mins.)_____How often? (Per wk) _____	

Please choose the type of diet you are currently on?

Type:	**How well do you follow diet:**			
☐ Regular				
☐ Low fat/Chol	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Low salt	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Diabetic	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Renal	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ No Added Salt	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Weight Loss	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Low Carb	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Vegetarian	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet

Reviewed By:_____

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ AGE: _____

FAMILY HISTORY ☐ Adopted

Please indicate below if your FATHER, MOTHER, SIBILING(S), or CHILDREN have ever been diagnosed with any of the following conditions, by writing the **age** (not a check mark!) at which the condition first occurred in the appropriate box. **PLEASE NOTE**: If there is no history of these conditions or if they are unknown, THEN check the **None** or **Unknown** box in the appropriate column.

Condition	Father	Mother	Sister(s)	Brother(s)	Child(ren)
Angina					
Heart Attack					
Angioplasty					
Heart Surgery					
Abnormal Heart Rhythm					
Sudden/Unexpected Death					
Stroke/TIA (mini stroke)					
Blood Clots					
Heart Failure/Cardiomyopathy					
Aneurysm					
None of the above					
Unknown					
Current age					
Deceased age					

Other family members (aunts, uncles, cousins, grandparents) with heart problems:

_____

_____

Reviewed By:_____

New Patient Medical Questionnaire

Patient Name:_____ DOB:_____ AGE: _____

REVIEW OF SYSTEMS

Please check the "Yes" or "No" box to indicate if you are experiencing or have experienced any of the following signs or symptoms in the last three months.

CONSTITUTIONAL:	**YES**	**NO**
Significant weight loss	☐	☐
Significant weight gain	☐	☐

ENMT:	**YES**	**NO**
Excessive Snoring	☐	☐

RESPIRATORY:	**YES**	**NO**
Coughing up blood	☐	☐

GASTROINTESTINAL:	**YES**	**NO**
Blood in stools (black stools)	☐	☐

GENITOURINARY:	**YES**	**NO**
Blood in urine	☐	☐

VASCULAR:	**YES**	**NO**
Calf pain with walking	☐	☐

MUSCULOSKELETAL:	**YES**	**NO**
Muscle pain at rest	☐	☐

NEUROLOGICAL:	**YES**	**NO**
Dizziness	☐	☐

PSYCHIATRIC:	**YES**	**NO**
Excessive stress	☐	☐

ENDOCRINE:	**YES**	**NO**
Feel cooler than others	☐	☐

HEMATOLOGICAL:	**YES**	**NO**
Unusual bleeding	☐	☐

CARDIAC:	**YES**	**NO**
Chest pain	☐	☐
Chest pressure	☐	☐

	YES	**NO**
Shortness of breath	☐	☐
Difficulty breathing while laying flat	☐	☐
Awakening with breathing difficulty	☐	☐

	YES	**NO**
Swelling in feet/ankles	☐	☐

	YES	**NO**
Palpitations	☐	☐

	YES	**NO**
Nearly passing out spells	☐	☐
Passing out spells	☐	☐

Any other reason why you need to see a cardiologist?

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

Patient Signature _____

Reviewed By:_____