

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



How did you hear about HeartPlace?

Physician Referral Advertisement
 Friend Other: _____ Date: _____

Patient Information

Name: _____ last first middle Doctor: _____
 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

Patient Name: _____ DOB: _____ DATE: _____

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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiomegaly (Enlarged Heart) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary Artery Disease _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease you were born with(congenital)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Failure / Cardiomyopathy _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arrhythmia / Abnormal Rhythm _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Murmur _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous Cardiac Arrest _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Heart Valve _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Defibrillated / Shocked _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocarditis (infected heart valve)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pericardial(sac surrounding heart) Disease _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal ECG _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Marfan's Syndrome _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Angina (heart pain) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospitalized for cardiac reasons _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other type of heart disease _____ |

VASCULAR:

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Carotid Artery Disease _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke or TIA (mini-stroke) _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal(kidney) Artery Disease _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any history of aneurysm _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Peripheral(leg or arm) Artery Disease _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | DVT (clots in leg) _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pulmonary embolism (clots in lung) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other type of vascular Disease _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins _____ | | |

CORONARY RISK FACTORS

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension (high blood pressure) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Mellitus _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Cholesterol / Triglycerides _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently Smoking? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | History coronary disease in immediate family? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Peripheral artery disease? (legs, carotids) _____ |

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

CARDIAC PROCEDURES/DIAGNOSTIC TESTING

Yes No

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

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

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:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema / COPD _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Apnea _____ |

GASTROINTESTINAL:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Reflux(GERD) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Hiatal Hernia _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diverticulosis / Diverticulitis _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease / Hepatitis _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Gastritis _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder Disease / Gallstones _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal Bleed _____ |

RENAL / GENITOURINARY:

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dialysis _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Disease _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Stones _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease / Elevated Creatinine _____ |

NEUROLOGICAL / PSYCHOLOGICAL:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Intracranial (in the brain) Bleeding _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure Disorder _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine Headaches _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Dementia _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety Disorder _____ |

FEMALE REPRODUCTIVE: Not Applicable

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple miscarriages _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Currently Pregnant (number of weeks?) _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Menopause (at what age?) _____ | |

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

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 Do Not Resuscitate 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
<input type="checkbox"/> Cigarettes	_____ per day	Years Smoked? _____ Quit Date? _____
<input type="checkbox"/> Cigars	_____ per day	Years Smoked? _____ Quit Date? _____
<input type="checkbox"/> Pipes	_____ per day	Years Smoked? _____ Quit Date? _____
<input type="checkbox"/> 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:
<input type="checkbox"/> Beer	_____ cans per day / wk / mo / yr
<input type="checkbox"/> Wine	_____ glasses per day / wk / mo / yr
<input type="checkbox"/> Spirits	_____ glasses per day / wk / mo / yr

Do you use caffeine? Yes Formerly Never

Type:	How much:	Quit (when)
<input type="checkbox"/> Caffeinated Coffee?	_____ cups per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____
<input type="checkbox"/> Caffeinated Tea?	_____ cups per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____
<input type="checkbox"/> Caffeinated Soda?	_____ cans per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____
<input type="checkbox"/> Chocolate?	_____ servings per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

Do you use recreational drugs? Yes Formerly Never

Type:	How much:	Start/Quit Dates
<input type="checkbox"/> Marijuana	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____
<input type="checkbox"/> Cocaine	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____
<input type="checkbox"/> Methamphetamine	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____
<input type="checkbox"/> Other	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____

Exercise?

No/Sedentary Occasional Regular Active Lifestyle Physically Unable to exercise

Type:	How much:	Check any applicable:
<input type="checkbox"/> Aerobics	How long? (Mins.) _____ How often? (Per wk) _____	<input type="checkbox"/> Started Exercising
<input type="checkbox"/> Cycling	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Dancing	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Jogging	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Running	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Swimming	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Team sports _____	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Walking	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Weights	How long? (Mins.) _____ How often? (Per wk) _____	

Please choose the type of diet you are currently on?

Type:	How well do you follow:			
<input type="checkbox"/> Regular	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Low fat/Chol	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Low salt	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Renal	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> No Added Salt	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Low Carb	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

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:

Significant weight loss YES NO
Significant weight gain YES NO

CARDIAC:

Chest pain YES NO
Chest pressure YES NO

ENMT:

Excessive Snoring YES NO

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

RESPIRATORY:

Coughing up blood YES NO

Swelling in feet/ankles YES NO

GASTROINTESTINAL:

Blood in stools (black stools) YES NO

Palpitations YES NO

GENITOURINARY:

Blood in urine YES NO

Nearly passing out spells YES NO
Passing out spells YES NO

VASCULAR:

Calf pain with walking YES NO

Any other reason why you need to see a cardiologist?

MUSCULOSKELETAL:

Muscle pain at rest YES NO

NEUROLOGICAL:

Dizziness YES NO

PSYCHIATRIC:

Excessive stress YES NO

ENDOCRINE:

Feel cooler than others YES NO

HEMATOLOGICAL:

Unusual bleeding YES NO

Thank you for taking the time to complete this questionnaire.

Patient Signature _____

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

CURRENT CARDIAC SYMPTOMS (circle all that apply)

1. Do you experience any chest pain, pressure or discomfort? YES NO

- a. **Approximate Date of first episode:** _____ **Approximate Date of last episode:** _____
- b. **Frequency (on average):** _____ times per day / week / month / year
- c. **Frequency status:** less frequent / more frequent / no change(stable)
- d. **Duration (on average per episode):** _____ seconds / minutes / hours / days / weeks
- e. **Duration status:** progressively longer / progressively shorter / no change(stable)
- f. **Pattern:** continuous / waxing/waning / intermittent / on/off
- g. **Location:** Under the sternum(breast bone) / along the sternum / left chest / right chest /
Left arm / right arm / jaw / neck / epigastric area (over stomach) / Other: _____
- h. **Radiate (travel) to another area:** Does not radiate / left arm / right arm / neck / jaw / shoulders / back / Other: _____
- i. **Quality:** dull / burning / aching / sharp / tightness / pressure / squeezing / Like previous angina
Unlike previous angina / Other: _____
- j. **Severity(circle one):** 1(minor) 2 3 4 5 6 7 8 9 10 (intense)
- k. **Severity status:** better / worse / no change / more nitro
- l. **Context:** sleep / at rest / stress / at work / exercise / movement
specific activity (type) _____ Other: _____
- m. **Relieving factors:** nothing / rest / Nitroglycerin-under tongue / Nitroglycerin-IV / oxygen / deep breath
/ narcotic medications / non-narcotic pain medications food / antacids / belching
change in position(type?) _____ / Other: _____
- n. **Aggravating factors:** Nothing / inspiration(deep breath) / lying down / sitting up
Exertion (type?) _____ / stress(type?) _____ /
Movement(type?) _____ / meals / exposure to cold / Other: _____
- o. **Associated factors:** None / nausea / vomiting / belching / sweats / palpitations
Dizziness / lightheadedness / shortness of breath / Other: _____

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

2. **Do you experience any shortness of breath NOT associated with chest pain? YES NO**

- a. Approximate Date of first episode: _____ Approximate Date of last episode: _____
b. Frequency (on average): _____ times per / day / week / month / year
c. Frequency status? More frequent / less frequent / no change
d. Duration (on average per episode)? _____ minutes / hours / days
e. Duration status? Progressively longer / progressively shorter / no change
f. Mode of onset? gradual / sudden
g. Severity? Minimal / mild / mild-to-moderate / moderate / moderate-to-severe / severe
h. Severity status? Better / worse / no change
i. Context(When do you get short of breath?): At Rest / stress / with activity (what type?) _____
j. How far can you walk before you get short of breath? _____ yards / blocks / miles
k. Do you need to sleep on more than 1 pillow to breathe? NO / YES, How many pillows? _____
l. Do you wake up in the middle of the night short of breath? NO / YES, How often? _____
m. Relieving factors: Nothing / fresh air / nebulizers / nitroglycerin / rest / oxygen / sitting / inhalers / medications oral prednisone / Other: _____
n. Aggravating factors: Nothing / anxiety/ stress / normal activities / bending forward / mild activity(walking) moderate activity (climbing stairs) / strenuous activity(running) / laying flat/ upper extremity activity/ Other: _____
o. Associated symptoms: none / anxiety / chest pain / cough / fever / leg swelling / sputum wheezing / palpitations / lightheaded / other: _____

1. **Do your legs swell? YES NO**

- a. Approximate Date of first episode: _____ Approximate Date of last episode: _____
b. Frequency(on average): _____ times per / week / month / year
c. Duration:(on average) _____ hours / days / weeks / months
d. Severity: Minimal / mild / mild to moderate / moderate / moderate to severe / severe
e. What is the location of the swelling: Foot / ankle / calf / knee / thigh / other: _____
f. Context(when do your legs swell?): Nothing / laying flat / sitting / standing / walking / other: _____
g. What relieves the swelling: Nothing compression stockings / leg elevation / lying flat / sitting / walking

Reviewed By: _____ 15



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

h. Associated symptoms: None / unusual weight gain / skin discoloration / ulcers / shortness of breath

4. Do you experience any palpitations (rapid heart beat or skipped beats)? YES NO

- a. Quality: rare skipped beats / occasional skipped beats / frequent skipped beats / flutter
sustained / regular / irregular / rapid heartbeat / other:
b. Approximate Date of first episode: Approximate Date of last episode:
c. Frequency of palpitations(on average): times per day / week / month / year
d. Frequency Status: more frequent / less frequent / no change/stable
e. Duration (per episode): seconds / minutes / hours / days
f. Duration status: longer / shorter / no change
g. Severity: Minimal / mild / mild-to-moderate / moderate / moderate-to-severe / severe
h. Severity status: increasing / decreasing / no change/stable
i. Context: None / sleep / rest / exertion(type?) / other:
j. Aggravating factors: None / anxiety / stress / caffeine / alcohol / Sudafed /
other-medications(type?) / Other:
k. Relieving factors: None / cough / neck massage / bearing-down / cold water to face
Exertion (type?) / medications (type?) / other:
l. Associated symptoms: None / shortness of breath / chest pain / dizziness / lightheadedness
near-fainting / fainting / other:

5a. Have you ever fainted (with loss of consciousness)? YES NO

5b. Have you ever felt dizzy or like you were going to faint or pass out YES NO

- a. Quality (circle all that apply): floating / imbalance / lightheadedness / spinning
unstable horizon / loss of consciousness(fainted)
b. Approximate Date of first episode: Approximate Date of last episode:
c. Frequency: times per day / week / month / year
d. Frequency status: more frequent / less frequent / no change/stable

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

- e. **Duration** (on average): _____seconds / minutes / hours / days
- f. **Context:** no warning / sitting to standing / abdominal pain/cramping / coughing / chest pain / other pain / nausea / palpitations / shortness of breath / ringing in ears / urination / bowel movement blood draw / fasting / vertigo / other: _____
- g. **Aggravating factors:** none / dehydration / change of position(type?) _____ / head turning exercise(type?) _____ / medications (type?) _____ other: _____
- h. **Relieving factors:** none / lying down / sitting / rest / medications (type?) _____ Other: _____
- i. **Associated symptoms:** none / confusion / seizure / seizure-like activity / headache slurred speech / visual changes / weakness / chest pain / palpitations / shortness of breath / other: _____

6. Any other reason why you need to see a cardiologist?

Thank you for taking the time to complete this questionnaire.

Patient Signature _____

Reviewed By: _____