Heart Care 360
Cardiology and Vein Center

New Patient Health Questionnaire **Date:** ___/___/___

Patient: _____ Gender: **M** **F**

Date of Birth: ___/___/___ Age:___ Occupation_____

Referring Doctor:_____

Reason for your visit: _____

Prior Heart Disease and Testing:

Heart murmur/Valve Prolapse….**NO YES**
Rheumatic/Scarlet Fever……. **NO YES**
Angina/Chest Pain…….. **NO YES**
Heart Attack…… **NO YES**
Heart Cath/Angioplasty/Stent…. **NO YES**
Bypass Surgery……**NO YES**
Pacemaker…….. **NO YES**
Defibrillator…… **NO YES**

Heart Failure……**NO YES**
Stress Test……....**NO YES**
Echo/Ultrasound.....**NO YES**
Calcium Scoring…....**NO YES**
Carotid Ultrasound……**NO YES**
CT Angiogram……...**NO YES**
Holter Monitor…….. **NO YES**
Nuclear PET scan……..**NO YES**

Risk Factors For Heart Disease:

Numbness/Tingling of legs..…... **NO YES**
Female menopause…… .**NO YES**
Stroke or TIA (ministroke)…….. **NO YES**
Current Smoker……... **NO YES**
Previous Smoker…… **NO YES**

Diabetes……..……**NO YES**
Leg Cramps walking..... **NO YES**
Venous (leg) clots…..... **NO YES**
Pulmonary embolism…. **NO YES**
Quit: Year:_____

Medications:
Please list all prescription and non-prescription medicines including vitamins and aspirin.

	Name	Dose/Strength	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

DO YOU HAVE ANY ALLERGIES TO MEDICATION? **NO** **YES**
Please list all medications to which you have an allergy or adverse response and list the reaction.

	Medication	Reaction
1.		
2.		
3.		
4.		
5.		

Do you have an allergy to IODINE, SHRIMP, or SHELLFISH? **NO** **YES**
Have you received X-ray contrast (IVP, myleogram, CT san) **NO** **YES**
If yes, did you have any reaction to the contrast? **NO** **YES**

FAMILY HISTORY
Please indicate with an **X** all those immediate family members with the following conditions.

	Father	Mother	Brother(s)	Sister(s)
1. Angina				
2. Heart Attack				
3. Angioplasty/Stent				
4. Heart Bypass				
5. Other Heart Surgery				
6. Heart Failure				
7. Stroke				
8. Heart Valve Problem				
9. Congenital Heart Disease				
10. Hypertension				
11. Abnormal Cholesterol				
12. Diabetes				
13. Abdominal Aortic Anuerysm				
14. Pacemaker/AICD				
15. Sudden Death				

Father's age at death and cause, if deceased:_____
Mother's age at death and cause, if deceased:_____
Brother/Sister age at death and cause if deceased: _____

Please list all past surgeries/hospitalizations and dates: _____
_____
_____
_____
_____
Briefly describe any other past medical problems:_____
_____
_____

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PATIENT REGISTRATION FORM

Today's date			❑ Office ❑ Facility ❑Home	
PATIENT INFORMATION				
Patient's Name Last First MI				Single / Mar / Div / Sep / Wid
Date of Birth	Age	❑ M ❑ F	Social Security #	Driver's License #
Street address			City, State, Zip	
Phone (day)	Phone (evening, cell)		Email address	
Referred By	Race		Ethnicity	Primary Language
Pharmacy Name	Pharmacy Address			Pharmacy Phone
IN CASE OF EMERGENCY				
Emergency Contact			Relationship to patient	
Street address			City, State, Zip	
Phone (day)			Phone (evening, cell)	
INSURANCE INFORMATION				
❑ **Medicare** ❑ **Medicaid** ❑ **HMO** ❑ **PPO** ❑ **POS** ❑ **PPC**			❑ **Worker's Comp** ❑ **Auto Accident Date of Injury / /**	
Primary Insurance Name			**WC or Auto Insurance Company**	
Address			Address	
City, State, Zip			City, State, Zip	
Phone	Fax		Employer at time of injury	
Policy Subscriber Name			Address	
Patient's relationship to subscriber			City, State, Zip	
Subscriber ID# or Social Security #			Phone	Fax
Plan Name			Claim #	
Policy #	Group #		Claim Adjuster	
Primary Care Physician			Phone	Fax
Phone	Fax		Case Manager	
Secondary Insurance Name			Phone	Fax
Address			Name of attorney	
City, State, Zip			Contact Person	
Policy #	Group #		Phone	Fax
Phone	Fax		Lawsuit pending? ❑ Yes ❑ No	
Policy Subscriber Name			Auto accident deductible: $	Met? ❑ Yes ❑ No
Patient's relationship to subscriber			LIEN? ❑ Yes ❑ No	LOP? ❑ Yes ❑ No
CO-PAY? $	Self-pay? ❑ Yes ❑ No			
EMPLOYMENT INFORMATION				
Employer			Occupation	
Street Address			City, State, Zip	
Phone	Fax		Email	

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: Last First MI

Today's Date: **Reason for Visit:**

Previous or referring doctor: **Patient sex :** ☐ **M** ☐ **F** **DOB:**

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

☐ AIDS/HIV +	☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Stroke
☐ Anemia	☐ Cataracts	☐ Gout	☐ Migraine Headache	☐ Thyroid Problems
☐ Anxiety	☐ Chicken Pox	☐ Heart Disease	☐ Mononucleosis	☐ TB
☐ Arthritis	☐ Depression	☐ Hepatitis	☐ Multiple Sclerosis	☐ Ulcers
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Pneumonia	LIST ANY OTHERS
☐ Bleeding Disorders	☐ Eating Disorder	☐ High Cholesterol	☐ Prostate Problem	☐
☐ Breast Lump	☐ Emphysema/COPD	☐ Hypertension	☐ Rheumatic Fever	☐
☐ Bronchitis	☐ Epilepsy	☐ Kidney Disease	☐ Sexually Transmitted Disease	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Do you know your blood type? ☐ Yes ☐ No Type:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	Drug Name	Strength	Frequency Taken
1			6		
2			7		
3			8		
4			9		
5			10		

Allergies to medications

Drug Name	Reaction You Had	Drug Name	Reaction You Had
1		3	
2		4	

Vaccines

Vaccine name	Date Received	Vaccine Name	Date Received
1		3	
2		4	

PATIENT NAME:					DOB:			
HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY) ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.								
Exercise	☐ Sedentary (No exercise)	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)							
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)							
Diet	Are you dieting?				☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?				☐	Yes	☐	No
	# of meals you eat in an average day?							
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola				
	# of cups/cans per day?							
Alcohol	Do you drink alcohol?				☐	Yes	☐	No
	If yes, what kind?							
	How many drinks per week?							
Tobacco	Do you use tobacco?				☐	Yes	☐	No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day				
	☐ # of years: _____	☐ Or year quit: _____						
Drugs	Do you currently use recreational or street drugs?				☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?				☐	Yes	☐	No
Personal Safety	Do you live alone?				☐	Yes	☐	No
	Do you have frequent falls?				☐	Yes	☐	No
	Do you have vision or hearing loss?				☐	Yes	☐	No
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?				☐	Yes	☐	No

FAMILY HEALTH HISTORY

Relation	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Is stress a major problem for you?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No
Have you ever been to a counselor?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	Yes	☐	No

SCREENINGS (please indicate most recent date)

Last Colonoscopy: / / ☐ Normal ☐ Abnormal	Cholesterol Screening: / / ☐ Normal ☐ Abnormal
Test for blood in stools: / / ☐ Normal ☐ Abnormal	Electrocardiogram: / / ☐ Normal ☐ Abnormal

PATIENT NAME: **DOB:**

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Wt. loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

ALLERGY/IMMUNO
- ☐ Rashes/hives/welts
- ☐ Itchiness
- ☐ Allergic asthma/bronchitis

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance problems
- ☐ Seizures
- ☐ Numbness

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

GENITOURINARY
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids
- ☐ Nausea

HEM/LYMPH
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Lack of energy

RESPIRATORY
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Sleeping problems
- ☐ Persistent cough
- ☐ Asthma

CARDIOVASCULAR
- ☐ History of Rheumatic fever
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling hands
- ☐ Swelling feet
- ☐ Irregular heart beat
- ☐ High or low blood pressure

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

WOMEN ONLY

Age at menstruation: / /	Date of last PAP smear: / / ☐ Normal ☐ Abnormal
Number of pregnancies _____ Number of live births _____	Date of or age at last menstruation: / /
Last Mammogram: / / ☐ Normal ☐ Abnormal	Bone Density Screening: / / ☐ Normal ☐ Abnormal

Experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes	☐	No
Date of last rectal exam? / / ☐ Normal ☐ Abnormal				

MEN ONLY

Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times _____				
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam? / / ☐ Normal ☐ Abnormal				
Date of last PSA test (if any): / / ☐ Normal ☐ Abnormal				

Is there anything else you would like to discuss with the doctor?

_____

_____

I have reviewed this history with the patient for accuracy and completeness:

_____

Physician signature and date

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PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures (Living Will)

  ☐ I have ☐ I have NOT made a Living Will

- Health Care Surrogate

  ☐ I have ☐ I have NOT designated a Health Care Surrogate

- Durable Power of Attorney

  ☐ I have ☐ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with a packet of information and forms.

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

- Name: _____ Phone #: _____
- Name: _____ Phone #: _____

III. ☐ I understand that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL"

IV. Confidential messages (i.e., appointment reminders) ☐ May ☐ May **not** be left on answering machine or voicemail.

V. Please print the phone number where you want to receive calls about your appointments: _____

☐ I am fully aware that a cell phone is not a secure and private line.

_____ _____

PLEASE PRINT PATIENT NAME **DATE OF BIRTH**

_____ _____

LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

_____ _____, 20_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **TODAY'S DATE**

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CONSENT TO TREAT

I, the undersigned, voluntarily give consent to my Access Health Care Physicians, LLC medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ Date: _____ DOB: _____
Patient Printed Name

_____ Relationship to Patient: _____
Signature of Patient/Legal Representative

. . . . . .

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the Access Health Care Physicians, LLC Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ Date: _____
Signature of Patient/Legal Representative

. . . . . .

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

AUTHORIZATION AND ASSIGNMENT

I hereby authorize my Access Health Care Physicians, LLC practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Access Health Care Physicians, LLC (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Legal Representative Date