Cardiovascular Interventions, P.A.

Patient Information Sheet

(Please Print)

☐ New Patient
☐ Established Patient Update

Today's Date: ____________

PATIENT DEMOGRAPHIC INFORMATION

Last Name: ____________________________ First Name: ______________________ Middle: _______
Mailing Address: ____
City: _____________________________________ State: ____________________ Zip Code: ________
Home Phone: ____________________ Cell Phone: ________________ Work Phone: ___________
E-mail Address: ____
May we e-mail or U.S. mail practice news and brochures to you ☐ Yes ☐ No
Sex ☐ Male ☐ Female
Date of Birth (mm/dd/yyyy): ____________________ Social Security # _________________________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Spouse's Name (if applicable): _____________________________ Spouse's DOB: ____________
Spouse's Social Security #: _________________________________
Spouse's Contact number: _____________________ ☐ Home ☐ Cell ☐ Office

In the event I am not available, I authorize the verbal release of my medical condition, status, and/or test results over the telephone: ☐ Both ☐ to my answering machine ☐ to the specified authorized members listed below:

1.) ____ 2.) _____________________________________
3.) ____ 4.) _____________________________________

EMPLOYMENT INFORMATION

Patient's Company Name: ____
Address: ____ Phone: _______________________
City: _____________________________________ State: ____________________ Zip Code: ________

Spouse/Parent Company Name: ____
Address: ____ Phone: _______________________
City: _____________________________________ State: ____________________ Zip Code: ________

NEXT OF KIN

Name: ____ Phone: _______________________
Address: ____
City: _____________________________________ State: ____________________ Zip Code: ________
Relationship: ____

INSURANCE INFORMATION

PRIMARY:
Insurance Company Name: ____
Address: ____ Phone: ____________________
City: ________________________________ State: _________________ Zip Code: _______
Identification Number: __________________________ Group Number: __________________
Policy Holder: _________________________________
Relationship: ☐ Self ☐ Spouse ☐ Other: ___________

SECONDARY:
Insurance Company Name: ____
Address: ____ Phone: ____________________
City: ________________________________ State: _________________ Zip Code: _______
Identification Number: __________________________ Group Number: __________________
Policy Holder: _________________________________
Relationship: ☐ Self ☐ Spouse ☐ Other: ___________

PATIENT QUESTIONNAIRE

Did another Physician refer you? ☐ Yes ☐ No
If yes, please complete the following information so we can send a report to your referring physician.
Referring Physician Name: ____
Street Address: ________________________________
City_______________________ State:_____________________ Zip Code: ____________
Office Phone: ______________________ Office Fax: __________________________

If you have a primary care physician OTHER than your referring physician please complete the following information so we can send a report to your primary care physician.

Referring Physician Name: ____
Street Address: ________________________________
City_______________________ State:_____________________ Zip Code: ____________
Office Phone: ______________________ Office Fax: __________________________

Would you like the report from today's appointment be sent to any physician other than those listed above? ☐ Yes ☐ No
Physician Name: ____
Street Address: ________________________________
City_______________________ State:_____________________ Zip Code: ____________
Office Phone: ______________________ Office Fax: __________________________

What is your **Chief Complaint** or reason for your appointment today?
____
____
____

ALLERGY HISTORY

Have you ever had an allergic reaction to any medication? ☐Yes ☐No

If Yes, please list medication and the reaction.

____

____

CURRENT MEDICATIONS

Please list any medications (Prescription and nonprescription) you are currently taking, Including vitamins and aspirin. Please use a separate sheet if necessary.

Medication	Dosage	Number taken Daily

PAST MEDICAL HISTORY

SYSTEM	Yes	No	Level #	Date of Result/Explain
CARDIOVASCULAR				
Atrial Fibrillation	☐	☐		
Blood Clotting Disorder	☐	☐		
Carotid Artery Disorder	☐	☐		
Congestive Heart Failure	☐	☐		
Elevated Cholesterol	☐	☐		
Heart Murmur	☐	☐		
Heart Attack/Angina	☐	☐		
Heart Surgery/Angioplasty	☐	☐		
High Blood Pressure	☐	☐		
GASTROINTESTINAL/ GENITOURINARY/RESPIRATORY				
Stomach Ulcers	☐	☐		
Liver Disease/Hepatitis	☐	☐		
Kidney/Bladder Disease	☐	☐		
Lung Disease	☐	☐		
Tuberculosis	☐	☐		
OTHER				
Alcohol Dependency	☐	☐		
Cancer	☐	☐		
Diabetes	☐	☐		
Drug Abuse	☐	☐		
Immune System Disorder	☐	☐		
Thyroid Disease	☐	☐		
Toxic Exposure	☐	☐		
Sexually Transmitted Disease	☐	☐		

Other Medical Problems: (Please list all medical conditions not listed above)
____
____
____
____
____
____

Previous Operations/Hospitalizations:

Date	Hospital (City, St)	Problem/Operation
______________	______________________	__________________________
______________	______________________	__________________________
______________	______________________	__________________________
______________	______________________	__________________________
______________	______________________	__________________________

FAMILY HISTORY

	Age (or age at death)		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandmother** *Maternal*	☐ living		
	☐ M ☐ F			**Grandfather** *Maternal*	☐ living		
	☐ M ☐ F			**Grandmother** *Paternal*	☐ living		
	☐ M ☐ F			**Grandfather** *Paternal*	☐ living		

SOCIAL HISTORY

Birthplace: ____________________________Highest degree completed in School: ______________
Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower
How many Children do you have? _____________
Current Occupation: ___________________________________
What are your hobbies?: ____
Who currently lives at home with you? ____

Do you Exercise? ☐Yes ☐No If yes, how much? ☐Rarely ☐Occasionally ☐>3 times per wk
Do you have any Dietary Restrictions? ☐Yes ☐No If yes, what type _______________________

TOBACCO HISTORY

Have you ever smoked cigarettes? ☐Yes ☐No
If yes, how much do you currently smoke per day? ☐None ☐1/2 pack ☐1 pack ☐>1 pack
If you have previously smoked, how long ago did you quit? ☐1 yr ☐1-5 yrs ☐>5 years
How many years did you smoke? ________

SUBSTANCE HISTORY

Have you had significant exposure to: ☐Pesticides ☐Toxic Waste ☐None
Do you drink Alcohol? ☐Yes ☐No Type:_______________
How much per week ____________
Have you or do you take street drugs?: ☐Yes ☐No If yes, state type: __________________

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms? Please mark yes or no.
If yes, please give a brief explanation

SYSTEM	*Yes*	*No*	*Explanation*
ALLERGY/IMMUNOLOGY			
Low resistance to infection	☐	☐	
Environmental allergies	☐	☐	
CARDIOVASCULAR			
Chest Pain or Angina	☐	☐	
Irregular heart rhythm	☐	☐	
Swelling of the feet, ankles or hands	☐	☐	
CONSTITUTIONAL			
Good General health lately	☐	☐	
Recent weight changes	☐	☐	
Extreme Fatigue	☐	☐	
Frequent nausea and/or vomiting	☐	☐	
Difficulty sleeping	☐	☐	
EARS, NOSE, MOUTH, THROAT			
Change in hearing	☐	☐	
Ringing in the ears	☐	☐	
Recent nose bleeds	☐	☐	
Chronic sinus problems	☐	☐	
Voice changes	☐	☐	
EYES			
Wear glasses, contact lenses	☐	☐	
Change in Vision	☐	☐	
Glaucoma	☐	☐	
ENDOCRINE			
Heat or cold intolerance	☐	☐	
Excess thirst or urination	☐	☐	
GASTROINTESTINAL			
Change in appetite	☐	☐	
Severe heart burn	☐	☐	
Vomiting blood	☐	☐	
Frequent diarrhea	☐	☐	
Constipation	☐	☐	

Black or bloody stools	☐	☐	
Abdominal pain	☐	☐	
GENITOURINARY			
Blood in urine	☐	☐	
Burning with urination	☐	☐	
Difficult/frequent urination	☐	☐	
Lack of bladder control	☐	☐	
Sexually transmitted disease	☐	☐	
Change in sexual function	☐	☐	
HEMATOLOGY/LYMPHATIC			
Easy bruising	☐	☐	
Frequent bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
INTEGUMENTARY SKIN & BREASTS			
Unusual or prolonged rashes	☐	☐	
Breast pain or lump	☐	☐	
Change in hair or nails	☐	☐	
MUSCULOSKELETAL			
Joint/muscle stiffness or pain	☐	☐	
Weakness of muscles or joints	☐	☐	
Back pain	☐	☐	
Difficulty walking	☐	☐	
NEUROLOGICAL			
Headaches	☐	☐	
Numbness or tingling sensation	☐	☐	
Weakness or paralysis	☐	☐	
Convulsions or seizures	☐	☐	
Change in memory or concentration	☐	☐	
Loss or blurring of vision	☐	☐	
Double vision	☐	☐	
Blackouts or dizziness	☐	☐	
Memory loss or confusion	☐	☐	
Other neurological problems	☐	☐	
PSYCHIATRIC			
Nervousness	☐	☐	
Depression	☐	☐	
Other	☐	☐	
RESPIRATORY			
Breathing problems or shortness of breath	☐	☐	
Coughing up blood	☐	☐	
Chronic cough	☐	☐	

By signing below you are verifying that above stated information is true.
Patient Signature: ____
Patient Printed Name: ______________________________ Date of Signature:__________