

Patient Name: _____ Date of Birth: _____ Date: _____

Past Medical History

Please check and add details out to the side

Have you ever been told that you had:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lipid disorder |
| <input type="checkbox"/> Aneurysm: abdominal <input type="checkbox"/> thoracic | <input type="checkbox"/> MI (heart attack) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> MVP (mitral valve prolapse) |
| <input type="checkbox"/> Atrial Flutter | <input type="checkbox"/> PAH (Pulmonary Artery Hypertension) |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> PUD (peptic ulcer disease) |
| <input type="checkbox"/> Claudication | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> PVD (peripheral vascular disease) |
| <input type="checkbox"/> Connective Tissue Disease (Lupus, Sarcoidosis, etc) | <input type="checkbox"/> Renal Failure <input type="checkbox"/> Insufficiency |
| <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Rheumatic heart disease |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes (insulin or non-insulin dependent) | <input type="checkbox"/> SVT (supraventricular tachycardia) |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> TB (tuberculosis) |
| <input type="checkbox"/> Gastrointestinal Bleed | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Gastroesophageal reflux disease (GERD) | <input type="checkbox"/> TIA (transient ischemic attack) |
| <input type="checkbox"/> Heart block | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ventricular Tachycardia |
| <input type="checkbox"/> Irregular heart rhythm | |

Surgical History

Please check and list date / facility / surgeon

- Abdominal Surgery _____
- Amputation: above knee
- Amputation: below knee
- Anesthesia Problems
- Aneurysm Repair
- Aortic Valve Repair Replacement
- Appendectomy
- Arteriogram carotid legs kidneys
- Bypass: Aorta-femoral left right
- Bypass: Fem-pop left right
- CABG (Open heart)
- Congenital heart surgery
- Endarterectomy Lt carotid Rt carotid
- EPS (Electrophysiology Study)
- Gallbladder surgery
- Heart Cath (dye test)
- ICD (Defibrillator) ICD : Bi-V
- Mitral Valve Repair Replacement
- Pacemaker
- PTCA (Angioplasty / stent) heart
- PTCA (Angioplasty / stent) leg kidney
- Stent Aorta Carotid Iliac
- Surgical Complications
- Thyroid surgery

Other operations _____

Patient Name: _____

Date: _____

Home Medications

List all medications & dosage you are presently taking and how frequently you take them:

Medication / Dose / Frequency

Please list all known allergies:

Family History

Please check and add any details out to the side

- | | |
|--|--|
| <input type="checkbox"/> Unknown | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Aortic Aneurysm | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Asthma | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Bleeding Disorder | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Cancer _____ | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Congestive Heart Failure | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Connective Tissue Disease | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Coronary Artery Disease | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Coronary Heart Disease-male < 55 | [father, sibling, grandparent] |
| <input type="checkbox"/> Coronary Heart Disease-female < 55 | [mother, sibling, grandparent] |
| <input type="checkbox"/> CVA or Stroke | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Diabetes | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Hyperlipidemia (cholesterol problems) | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Hypertension | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Marfan's Syndrome | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> PAH (Pulmonary Artery Hypertension) | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Peripheral vascular disease | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Prolonged QT | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Renal Disease | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Sudden Cardiac Death | [father, mother, sibling, grandparent] |
| <input type="checkbox"/> Thyroid Disease | [father, mother, sibling, grandparent] |

Please circle family member(s) where applicable

Mother living? Yes No Age at death _____ Father living? Yes No
Age at death _____ Number of living brothers & sisters _____ Number of deceased brothers & sisters _____

Social History

Marital Status: Single, Married, Divorced, Widowed

How many children do you have? _____

What is your occupation: _____

Disabled Retired

Smoking History:

Current Smoker: year started _____

Cigarettes: _____ packs per day

Cigars: _____ number per week

Smokeless: _____ amount per day

Counseled to quit or cut down: Yes No

Former smoker: year quit _____

Never smoked:

Passive smoke exposure Yes No

Do you drink alcoholic beverages? Yes No

Types of Alcohol? _____

How many drinks per day? _____

Drug Use? Yes No (If yes circle type below)

Marijuana, cocaine, crack, heroin, illicit prescription
Other _____

Do you drink caffeinated drinks? Yes No

How many per day? _____

Do you drink diet drinks? Yes No

Are you on a special diet? Yes No

- | | |
|-----------------|-----------------|
| Calorie Limited | Low Salt |
| Low Fat | Diabetic |
| High Fiber | Low Cholesterol |
| Other _____ | |

Do you exercise on a regular basis? Yes No

How many times per week? _____

Type of exercise? _____

Do you have a barrier to communication? Yes No
(If yes, circle impairment below)

- | | |
|----------------------|--------------------|
| Non-English Speaking | Hearing Impairment |
| Vision Impairment | |

High Risk Behavior? Yes No

Comments: _____

Cardiology Consultants

Patient Name: _____ Date of Birth: _____ Date: _____

Review of Systems (please check if you have any of the following)

General

- Daytime sleepiness
- Weakness
- Weight Gain
- Weight Loss

Cardiovascular

- Chest pain
- Fainting
- Heart racing (palpitations)
- Swelling in feet/legs (peripheral)

Respiratory

- Cough
- Excessive snoring
- Shortness of breath
- Wheezing

Neurologic

- Dizziness (lightheadedness)
- Morning headaches

Gastro-Intestinal

- Constipation
- Diarrhea
- Bloody stools
- Indigestion
- Dark tarry stools
- Nausea
- Vomiting

Genital-Urinary

- Difficult urination (dysuria)
- Blood in urine (hematuria)

Musculo-Skeletal

- Leg pain
- Muscle cramps

Dermatologic

- Non-healing ulcer
- Scar to chest
- Scar to leg

Ears, Nose, Throat

- Hoarseness
- Nosebleed

Psychiatric

- Anxiety
- Depression

Allergies

- Allergic to dye
- Allergic to iodine
- Allergic to medications
- Allergic to shellfish

Form Completed By _____

Physician Signature _____

___ William A. Hill, Jr., M.D.
___ Jeffrey K. Anderson, M.D.
___ L. Anne Lewis, M.D.

CARDIOLOGY CONSULTANTS, P.C.
PATIENT INFORMATION

___ John A. Mantle, M.D.
___ Amit Shah, M.D.
___ Gregory Hamrick, CRNP
___ Holley Turner, CRNP

DATE: _____ **ACCT. NUMBER:** _____

Patient Name: _____
(First) (Middle) (Last)

Date of Birth: _____ **Age:** _____ **Marital Status: Married/Single**
(Circle)

Mailing Address: _____
(Street) (City) (Zip Code)

Phone Numbers: Home: _____ **Cell:** _____ **Work:** _____

E-mail: _____ **Male or Female** **Social Security No:** _____

Did another physician refer you here? Y / N **Referring physician:** _____

Who is your family physician? _____

Language: English/Spanish/Other **Race:** _____ **Ethnicity: Nonhispanic/Hispanic**
(circle) (circle)

Employed: Y / N / Retired **Employer:** _____

Spouse's Name: _____ **Spouse's Employer:** _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance Name: _____ **Effective Date:** _____

Contract Number: _____ **Group Number:** _____

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

Employer Plan? Y / N **Employer:** _____

Patient's relation to insured party: Self / Spouse /Parent /Child /Other **Male / Female**

Secondary Insurance Name: _____ **Effective Date:** _____

Contract Number: _____ **Group Number:** _____

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

Employer Plan? Y / N **Employer:** _____

Patient's relation to insured party: Self/ Spouse /Parent /Child /Other **Male / Female**

**Please have your Driver's License and all Insurance Cards available for us to scan. Thank You.*

What is an alternate contact name and number of a person not living with you?

Name: _____ **Phone:** _____ **Relation:** _____

INSURANCE AUTHORIZATION

I hereby authorize Cardiology Consultants, P.C. to release any medical information needed by my insurance carriers in order to process my claim. I hereby authorize payments direct to Cardiology Consultants, P.C. I understand that it is my responsibility to provide correct insurance information to Cardiology Consultants, P.C. I understand that my insurance may not pay the bill and that some of the services may be considered "noncovered" by my insurance contract. I understand that I will be responsible for the balance of my account. In the event of a returned check, I understand that a \$25.00 fee will be charged to my account at Cardiology Consultants, P.C.

Patient's Signature(Agreement to Pay) **Date:** _____ **Guarantor's Signature(Agreement to Pay)** **Date:** _____