

Patient Information

Cardiologist: _____
Date: _____
Personal Information
Name (First) _____ (M.I.) _____ (Last) _____
Street Address _____
City _____ State _____ Zip _____ Home Phone (____) _____
Social Security # _____ Male _____ Female _____
Marital Status _____ Date of Birth _____
Employer Name _____
Employer Address _____
Employer Phone (____) _____ Occupation _____
Nearest Relative Not Living with You _____ Relationship _____
Address _____ Phone (____) _____

Spouse Information (or Parent if Patient is a Minor)

Name _____ Date of Birth _____
Social Security # _____ Employer Name _____
Address _____
Phone (____) _____ Occupation _____

Family Doctor

Name _____ Phone (____) _____

Insurance Information

Insurance Company _____
Name of Insured _____ Relationship to Patient _____
Group/Policy Number _____ ID Number _____
Insured's Employer _____
Insurance Company Phone _____

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by Fort Worth Heart, P.A., or on its premises, including physician services. I authorize any holder of information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or other benefits related to these services.

Signature of Patient _____ Date _____

I request that payment by _____ of any and all medical and/or surgical benefits to which I am entitled through private insurance or any other health plans, including major medical benefits, be made to: Fort Worth Heart, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Patient _____ Date _____

Revised 10/13/04



Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Fort Worth Heart ^{P.A.} creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)

DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

WITNESS (Optional)

DATE

FOR OFFICE USE ONLY

Room: _____

Date: _____



Fort Worth Heart^{P.A.}
NEW OFFICE PATIENT EVALUATION

Name _____ Male Female
Last First Middle Initial

Date _____ Age _____ Birth date _____ Marital Status _____

Referring physician _____
Name Location

Reason for seeing a cardiologist: _____

List all past hospitalizations and surgeries:

Date	Reason	Location

List other serious illnesses or injuries you have had:

Date	Description of Illness or Injury

List all physicians you currently see:

Name of physician	Reason for seeing	Location

List all medications you currently take, the dosage, and how often you take them: _____

Are you allergic to any medications? Yes No

If "yes", please list: _____

Please check any items that apply

- Heart trouble
- Taking heart medicines (currently or in the past)
- Heart attack
- Congestive heart failure
- Heart murmur
- Scarlet fever
- Rheumatic fever
- Born with a heart defect
- Been a "blue baby"
- Stroke
- Blood clots
- Phlebitis or Deep Venous Thrombosis
- Hypertension (high blood pressure)
- Diabetes
- High blood cholesterol
- High triglyceride
- Family history of heart disease
- Gone through menopause
- Heart surgery
- Bypass surgery
- Heart catheterization, arteriogram, angiogram
- Angioplasty
- Carotid artery surgery
- Vascular surgery
- Surgery to clean out or bypass blood vessels
- Vein stripping surgery
- Pain in your chest
- Pressure, heaviness, or tightness in the chest
- Shortness of breath
- Shortness of breath walking under one black
- Awakening from sleep short of breath
- Heart irregularity
- Atrial fibrillation, atrial flutter or other arrhythmia
- Have a pacemaker or defibrillator
- Fast or slow heartbeat
- Palpitations
- Blackout spells or fainting
- Temporary loss of vision, temporary loss of speech, or temporary paralysis
- Transient ischemic attack
- Pains in legs or hips when you walk
- Swelling in your ankles
- Ulcers on leg or feet
- Erectile dysfunction
- Taken a blood thinner
- Seizures
- Psychiatric or emotional problems
- Depression
- Anemia
- HIV or AIDS
- Cancer or tumors
- Thyroid or gland problems
- Lupus or rheumatoid arthritis
- Gout
- Asthma
- Bronchitis emphysema, lung problems, or COPD

- Stomach ulcers or bleeding ulcers
- Reflux or GERD
- Hepatitis, jaundice, or liver problems
- Colitis or colon polyps
- Urinary tract infections
- Kidney problems or kidney failure
- Kidney stones
- Bladder problems
- Prostate problems
- Skin conditions
- Orthopedic problems or surgery
- Fever, chills, or night sweats
- Weight loss or gain
- Severe headaches
- Rashes or itching
- Change in vision
- Change in mood
- Easy bruising or bleeding
- Ear, nose, or throat problems
- Cough, sputum, or wheezing
- Coughed up blood
- Nausea, vomiting, or diarrhea
- Sour belches, bad tastes in your mouth, or food coming up after meals
- Blood in stool (bowel movement)
- Dark black bowel movement
- Blood in urine
- Pain on urination
- Menstrual problems
- Could you be pregnant?
- Swollen joints
- Unusual thirst or appetite
- Back problems
- Drink alcohol:
Type and amount: _____
- Used drugs
Type of use and when last used: _____
- Caffeine use:
Type and amount _____
- Smoked cigarettes at any time
Packs per day: _____
Years smoked: _____
Still smoking Y N
When did you quit? _____

Please explain any checked items

Current diet:

Unrestricted Low salt Low fat Diabetic Other _____

Family history – Please check all applicable

	Parents	Grandparents	Aunts/Uncles	Siblings	Children
Heart attack or angina					
Heart failure					
Sudden cardiac death					
Hypertension					
High cholesterol					
Bleeding disorder					
Stroke					
Diabetes					
Alzheimer's disease					

Patient signature

Date

Name _____ Date _____ Age _____ Weight _____

BP lying _____ BP sitting _____ BP standing _____ Add BP _____ Pulse _____

The following were examined and were normal unless checked, or were unexamined if X'd:

- | | |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> General: Well developed, well nourished,
no acute distress | <input type="checkbox"/> Lifts _____ |
| <input type="checkbox"/> Head: Normocephalic, atraumatic | <input type="checkbox"/> Thrills |
| <input type="checkbox"/> Eyes: No xanthelasma, no arcus | <input type="checkbox"/> S ₁ <input type="checkbox"/> S ₂ (physiologic split A ₂ - P ₂) |
| <input type="checkbox"/> Carotid upstrokes <input type="checkbox"/> amplitudes | <input type="checkbox"/> S ₃ <input type="checkbox"/> S ₄ <input type="checkbox"/> rub |
| <input type="checkbox"/> Right carotid bruit <input type="checkbox"/> left carotid bruit | <input type="checkbox"/> Grade ____ /6 systolic murmur |
| <input type="checkbox"/> Jugular venous distention _____ | <input type="checkbox"/> Abdomen: No masses, bruits, organomegaly, tenderness |
| <input type="checkbox"/> Chest: Symmetric, no retractions | <input type="checkbox"/> Aortic pulsation abnormal |
| <input type="checkbox"/> Lungs: Clear to auscultation | <input type="checkbox"/> Extremities: No cyanosis, clubbing, or edema |
| <input type="checkbox"/> PMI in midclavicular line | <input type="checkbox"/> Pulses: ____ Radial ____ Femoral
____ Dorsalis pedis ____ Posterior tibial |

 ECG _____

 Chest x-ray _____

Additional comments: _____

Plan: BP check _____ Return appointment _____

Obtain old records from _____

Consult Dr. _____ for _____

-
- Enroll in Coumadin clinic
-
- Pacer implant
-
- Generator replacement
-
- Grafts
-
-
- PTCA
-
- Rotablator
-
- Other _____

Lab:
 Lipid profile LFT TFT CBC Chem-7 BNP Digoxin Other _____

Diagnostic:

- | | | |
|---------------------------------------------|-----------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Echo | <input type="checkbox"/> ECG | <input type="checkbox"/> L & CORS at _____ |
| <input type="checkbox"/> Stress echo | <input type="checkbox"/> Holter monitor | <input type="checkbox"/> L & R |
| <input type="checkbox"/> Dobutamine SE | <input type="checkbox"/> Event recorder | <input type="checkbox"/> Abdominal sonogram |
| <input type="checkbox"/> Adenosine thallium | <input type="checkbox"/> Chest x-ray | <input type="checkbox"/> Carotid sonogram |
| <input type="checkbox"/> Stress thallium | <input type="checkbox"/> V/Q scan | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> TEE | <input type="checkbox"/> PFT | |

NOTES: