PATIENT INFORMATION

Account #_______________

Patient's Name _______________

Home Phone _______________ Business Phone _______________ Social Security # ____/____/____

Address _______________

City _______________ State _______________ Zip Code _______________

Drivers License # _______________ Sex _______ Birthdate _______________

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Employment: Full-time ☐ Part-Time ☐ Laid-Off ☐ Unemployed ☐ Retired ☐

Employer _______________ Phone # _______________

May we contact you at your place of employment? Yes ☐ No ☐

Date of Retirement from Full-time Work __________ Company Name _______________

Family Physician _______________ Phone # _______________

Emergency Contact _______________

Home Phone _______________ Business Phone _______________

Person Responsible For Charges _______________ Relationship to Patient _______________

Home Phone _______________ Business Phone _______________

Address _______________

City _______________ State _______________ Zip Code _______________

Primary Insurance _______________ Phone # _______________

Mailing Address For Claims _______________

City _______________ State _______________ Zip Code _______________

Policy # _______________ Group # _______________

Name Of Policy Holder _______________ Relationship to Patient _______________

Policy Holders SS# _______________ Employer _______________

Secondary Insurance _______________ Phone # _______________

Mailing Address For Claims _______________

City _______________ State _______________ Zip Code _______________

Policy # _______________ Group # _______________

Name Of Policy Holder _______________ Relationship to Patient _______________

Policy Holders SS# _______________ Employer _______________

******************************** FOR OFFICE USE ONLY ************************

Has any member of your family been treated in this office? _______________

Has the insurance signature sheet been signed? _______________

Are current copies of insurance cards in the chart?

Date Verified/Initials _______________

____

Cardiac Consultants, P.C.

Review of Systems

NAME: ______________________

DATE: ______________________

Do you have diabetes? ☐ YES ☐ NO
Do you have high blood pressure? ☐ YES ☐ NO

Do you have:

	YES	NO
Chest pains	______	______
Shortness of breath	______	______
Ankle swelling	______	______
Palpitations	______	______
Blackout spells	______	______
TB	______	______
Chronic cough	______	______
Blood tinged sputum	______	______
Asbestos exposure	______	______
Leg cramps/burning	______	______
with activity	______	______
at rest	______	______

	YES	NO
Difficulty swallowing	______	______
Indigestion/heartburn	______	______
Stomach pains	______	______
Constipation	______	______
Diarrhea	______	______
Jaundice	______	______
Frequent urination	______	______
Blood in urine	______	______
History of kidney stone or infection	______	______
Prolonged fatigue	______	______
Gallbladder	______	______

Do you ever have to get up at night to pass urine? . . . . ☐ YES ☐ NO
Have you ever had an IVP (kidney x-ray)? . . . . ☐ YES ☐ NO

Do you have any back trouble, joint pain or arthritis? . . . . ☐ YES ☐ NO
Do you have trouble with skin rashes, infections or boils? . . . . ☐ YES ☐ NO

Do you bruise easily, have anemia, or swelling of the glands? . . . . ☐ YES ☐ NO

Do you get severe headaches? . . . . ☐ YES ☐ NO
Do you have a seizure disorder? . . . . ☐ YES ☐ NO

Do you have trouble with your hearing or eyesight? . . . . ☐ YES ☐ NO

Are you very nervous? . . . . ☐ YES ☐ NO
Have you ever been under the care of a psychiatrist or had a nervous breakdown? . ☐ YES ☐ NO

FOR WOMEN:

Number of pregnancies: ______________________
Are you pregnant now? ______________________
Date of last Pap smear ______________________

Number of living children ______________________
Date of last menstrual period ______________________
Date of last breast exam ______________________
Estrogen Therapy ______________________

WHAT DO YOU CONSIDER YOUR IMMEDIATE HEALTH PROBLEM (WHY ARE YOU HERE TODAY?)

____
____
____
____
____

SIGNATURE: ______________________
DATE: ______________________

Cardiac Consultants, P.C.

Patient History Form

MEDICAL HISTORY

NAME: ____________________

DATE: ____________________

Previous Operations and Dates:
1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Other hospitalizations:
1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

FAMILY HISTORY

Relation:	Age:	State of Health:	If deceased, cause and age
Mother			
Father			
Brothers			
Sisters			
Wife/husband			
Children			

Please list any relation who has had any of the following:

	RELATION
Diabetes	
Psychiatric	
High blood pressure	
Cancer	
Heart Trouble	
Anemia	
Tuberculosis (TB)	
Stroke	

ALLERGIES: ____________________

CURRENT MEDICATIONS:	DOSAGE:

Social History

Do you smoke? ☐ YES ☐ NO

If no, have you ever smoked? ☐ YES ☐ NO If yes, how long? ____________________

If yes, how much do you smoke in a day? Number of cigarettes ____________________

Cigars ____________________

Pipe ____________________

Have you ever used alcoholic beverages to excess or been treated for alcoholism? ☐ YES ☐ NO

Have you ever been treated for a drug habit? ☐ YES ☐ NO