Waco Cardiology Associates Information Sheet

rev 9/11 bm 6/07ss rev 11/05 12/07 bm 04/10 bm 05/11 kd 12/11 kd 01/12 kd

Please fill in all the information requested below (We will also need to copy your insurance cards)

Patient Information

Name: ______________ ______________ ______________
First Middle Last

Address: ______________ ______________
Number Street

______________ ______________ ______________
City State Zip code

Phone- Home: (_____) _____ - _______ Cell: (_____) _____ - _______ Work: (____) _____ - _______

Sex: M F Date of Birth: _____/_____/_____ Social Security No: _______ - _________ - _________

Race: ______________ Hispanic/Latino: Y N Preferred Language: ______________

Employment: FT PT Retired (date: ________) Employer: ______________ Phone: (_____) _____-_______

Marital Status: S M D W Spouse name: ______________ Spouse Employment: FT PT

Spouse Employer: ______________ Ph: (____) _____-_______ Retired (date: ________)

Living Will: Y N Organ/Tissue Donor: Y N Medical Power of Attorney: Y N

Name for Emergency Notification: ______________ Relationship: ______________

Address: ______________ Phone: (____) ______-_______

Primary Care Physician: ______________ Phone: (____) ______-_______

Referring Physician: ______________ Phone: (____) ______-_______

Is Patient In Hospice? Y N Is Patient In a Skilled Nursing Facility? Y N

Insurance/ Guarantor Information

Insurance policy holder, if different from Patient:

Name: ______________ DOB: ______________

Address: ______________ Phone: (____) _____-_____

If you are under 26 years old and covered by your parents insurances, please provide the following:

Mother's name: ______________ DOB: ______________

Father's name: ______________ DOB: ______________

I certify to the best of my knowledge that the above information is complete and correct. I authorize release of any information required in the processing of my claims. I further authorize my insurance benefits be paid directly to Waco Cardiology Associates. I understand that I am responsible for payment per the WCA Patient Payment Policy which has been made available to me.

Patient's Signature: ______________ Date: ______________

Your cardiologist may order diagnostic tests to assist him in the evaluation and treatment of your condition. These tests can be performed at Waco Cardiology Associates, however, if you prefer, you may request to have these tests scheduled at other local healthcare facilities.

Patient:
Social: LABEL
DOB

PAST HISTORY	YES	NO	COMMENTS
Previous Heart Attack			
High Blood Pressure			
Diabetes			
Rheumatic Fever			
Stroke			
Stomach/ Ulcers			
Asthma/ Emphysema			
Hiatal Hernia			
Thyroid			
Hyperlipidemia (high cholesterol or triglycerides)			
Other:			

SURGERIES	YES	NO	COMMENTS

Allergies

FAMILY HISTORY	YES	NO	RELATIVE
Coronary Artery Disease			
Peripheral Vascular Disease			
Hypertension			
Lipids/ Cholesterol			
Diabetes Mellitus			
Kidney Disease			
Sudden Cardiac Death/ Age			
Other:			

SOCIAL
Alcohol # per week Social? ____ Frequent? ____ None? ____
Exercise? Yes No Amount: ____________________
Caffeine- drinks per day: _____ Coffee ___ Tea ___ Soda ___
Ever Smoked? Y N Currently? Y N Packs/day ____ Yrs ____
Drug use? Y N Currently? Y N
Type: ____________ Frequency: __________
Marital Status: married divorced single widowed
Occupation:

Check if you have had any of the following systems in the last 6 months:

REVIEW OF SYSTEMS		YES	NO	COMMENT
CARDIOVASC	Chest Pain/ Pressure			
	Fast or irregular heart rate			
	Unexplained sweating			
	Short of breath when lying flat			
	Awakened by shortness of breath			
	Fainting			
	Pain in legs with walking			
	Swelling in feet			
CONST	Weight gain			
	Weight loss			
HEENT	Vision changes			
	Hearing loss			
RESP	Blood in sputum			
	Difficulty breathing			
GI	Nausea			
	Reflux/Heartburn			
	Blood in stools			

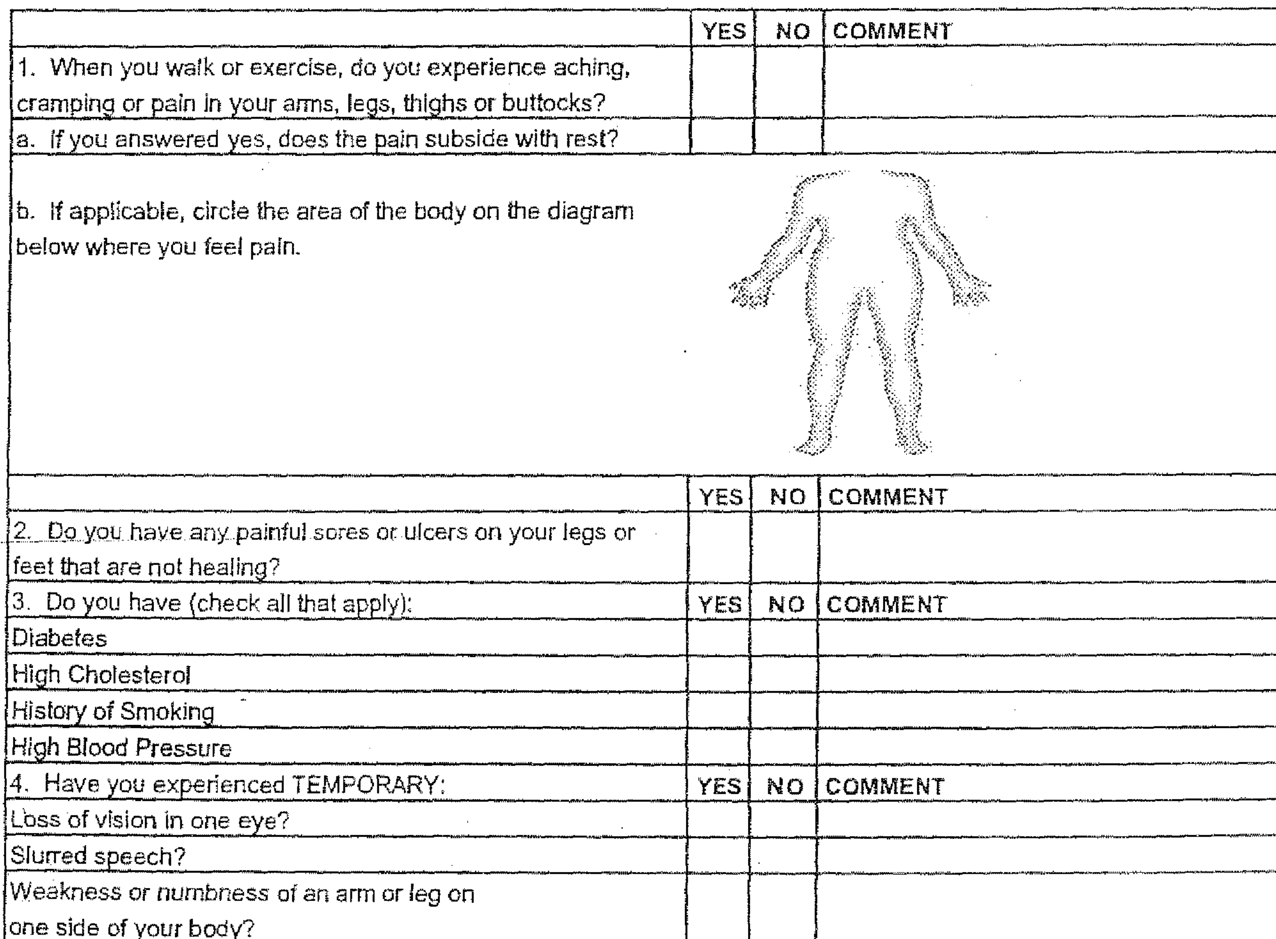
ROS continued		YES	NO	COMMENT
GU	Blood in urine			
	Frequent urination at night			
	Use of birth control pills			
	Erectile dysfunction			
NEURO	Dizzy/ Lightheaded			
	Seizures			
HEM	Anemia			
	Easy bruising or bleeding			
ENDO	Goiter			
	Tremors			
M/S	Joint pain			
	Muscle pain			
MOOD	Depression			
	Hallucinations			

Signature ______________________________

Patient:	
Social:	LABEL
DOB	-

Peripheral Vascular Disease Screening

Peripheral Vascular Disease (PVD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrow or clogged.



	YES	NO	COMMENT
1. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks?			
a. If you answered yes, does the pain subside with rest?			
b. If applicable, circle the area of the body on the diagram below where you feel pain.			
	YES	NO	COMMENT
2. Do you have any painful sores or ulcers on your legs or feet that are not healing?			
3. Do you have (check all that apply):	YES	NO	COMMENT
Diabetes			
High Cholesterol			
History of Smoking			
High Blood Pressure			
4. Have you experienced TEMPORARY:	YES	NO	COMMENT
Loss of vision in one eye?			
Slurred speech?			
Weakness or numbness of an arm or leg on one side of your body?			

____

Signature