# PATIENT INFORMATION SHEET

Date: ………………………………
Patient Name: …………………………………………………………………………
Responsible Party ( if other then self):…………………………………………………..
Address:……………………………………………………………………………………
City:………………………………….. State:……………………….. Zip: ……………
Home Telephone # : ……………………………Office Telephone #……………………...
Date of Birth: ……………………….Marital Status : …………..SS#……………………
Spouse's Date of Birth ………………Spouse Employed By: ……………………………
Spouse' Business Address : ………………………Spouse's Business # …………………
Referring Physician :……………………………or other then Referral Source…………

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## INSURANCE INFORMATION

Insurance Company Name________________________________________________
Policy #__________________________Subscriber______________________________
Group Name: ________________________Group #______________________________
Secondary Insurance Infor: Name:____________________________________________
Subscriber ___________________________Policy#____________________________

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## EMPLOYER INFORMATION

Employer Name :__________________________________________________________
Employer Address:_________________________________________________________
City:________________State:__________Zip Code:___________Phone#____________

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## OTHER INFORMATION

Emergency Contact Name:___________________________________________________
Relationship :__________________________ Telephone #________________________
Allergies:________________________________________________________________
Medication You are Presently taking:__________________________________________
Pharmacy:________________________________________________________________
Reason for Initial Visit:____________________________________________________

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OF NOT – PAID BY INSURANCE. I HERBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMAYION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I ASSIGN DIRECTLY TO YOUR OFFICE ALL INSURANCE BENEFITS. I AUTHORIZE THE USE OF THISSIGNATURE ON ALL INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRONIC.

______________________________________ ______________

PATIENT SIGNATURE DATE

Name:_______________________________ Age:_______________Date:____________

Past Medical History:

Diabetes Yes _______ No______________

Hypertension Yes _________No_________

Cholesterol Yes __________No__________

Smoker Yes ____________No___________

Heart attack Yes_________No___________

Heart Failure Yes_________No__________

Atrial fibrillation or arrhythmia Yes__________No_________

Knee pain Yes__________ No_______________

Lung problem Yes ________No______________

Others:____________________________________

Past Surgical History :

Bypass Surgery __________

Leg surgery _____________

Valve repair or replacement ____________

Pacemaker _______________

Defibrillator _______________

Appendectomy _______________

Tonsillectomy ________________

Cholecystectomy________________

Herniorrhaphy ___________________

Have you had any testing done and when:

Catheterization _______________

Echocardiogram ______________

Nuclear stress test_____________

PVR________________________

Carotid sonogram______________

Abdominal ultrasound __________

Holter monitor ________________

Famiy History: Have parents, siblings, grandparents had:

Heart problem ( Heart attack, bypass surgery, angioplasty) _______________

High blood pressure ________________________

Diabetes ___________________________________

Cancer _____________________________________

Social History :

Spouse's Name :________________________ DOB:_____________________

Children's Name :_____________________________________

Occupation :_______________________________ Status:__________________

Hobbies:____________________________________________________________

Complaints or symptoms: Please circle if you have or had any of the following:

CONSTITUTIONAL:
Weight loss
Fever
Chills
Fatigue
Aches

EYES:
Itching
Pains
Vision changes

EARS,NOSE OR THROAT:
Pain
Sore throat
Stuffy nose
Discharge
Ringing in the ears

CARDIOVASCULAR:
Chest pain/chest discomfort
Palpitation
Trouble breathing while sleeping
Have to sleep on more then one pillow
Shortness of breath with walking
Swollen legs
Leg pain with walking

RESPIRATORY:
Cough or sputum production
Shortness of breath
Wheezing
Snoring

GASTROINTESTINAL:
Nausea
Vomiting
Difficulty swallowing
Abdominal pains
Diarrhea
Constipation
Heartburn
Bleeding from the rectum

GENITOURINARY:
Trouble urinating
Urgency/frequency
Involuntary leaking of urine
Discharge

NEUROLOGICAL:
Headaches
Weakness
Slurred speech
Fainting
Dizziness
Numbness

INTEGUMENTARY:
Rashes
Skin lesions
Itching

ENDOCRINE:
Sweating
Heat or cold intolerance
Excessive or large production of urine
Excessive thirst