Florida Cardiac Consultants

Patient's Personal Information Date:___________________

Confidential Record: Information contained here will be used according to our Privacy Practice Notice

Patient's Full Legal Name:

____

(First) (Middle) (Last)

Address:_____________________________________ Cell#:__________________________

____ Work#:________________________

Northern Address (if applicable): Dates at Northern Address:

_____________________________________ ______________________________

____

Male__ Female__ SS#__________________ Marital Status (circle one): S M D W

Date of Birth:__________________ Spouse's Name:________________________

Employer:________________________________

Emergency Contact:________________________ Contact Phone Number:_________________

Relationship of Contact to Patient:____________

Family/PCP Physician:____

(First name) (Last name)

Family/PCP Address:____

Requesting Physician:____

<u>INSURANCE INFORMATION</u>

Primary Insurance Company/Address:____

Name of Policy Holder:____

Group/ID Number:____

Secondary Insurance Company/Address:____

Name of Policy Holder:____

Group/ID Number:____

Worker's Compensation:______________________ W/C #_______________________________

Original Date of Injury:________________________

Patient's Name:____ DOB____________

REASON FOR CONSULTING CARDIOLOGIST:____
____

PAST HISTORY:

Have you ever had?	If so, approximate date	Have you ever had?	If so, approximate Date
Jaundice	__________________	Diabetes	___________________
Asthma	__________________	Family History Heart Disease	___________________
Tuberculosis	__________________	Hypertension	___________________
Epilepsy	__________________	High Cholesterol	___________________
Anemia	__________________	Last Cholesterol check	___________________
Thyroid Disorder	__________________	History of Smoking	___________________
Stroke	__________________	Congestive Heart Failure	___________________
Peripheral Vasc Dis.	__________________	Heart Attack	___________________

SURGICAL:

Operations:	Approximate Year:
Heart and/or Valve	_______________
Angioplasty	_______________
Heart Cath	_______________
Tonsillectomy	_______________
Appendectomy	_______________
Hysterectomy	_______________
Other Operations:	_______________

____
____

MEDICATIONS: Please list below the medications you are currently taking, including non-prescription medications and vitamins.

Name of Medication	Dosage	How many times per day?
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________
________________________	______________	______________

ALLERGIES:
Please list all allergies that you may have. This would include allergies to any medications, iodine/dyes, foods, pollens, etc. ____
____

FAMILY HISTORY:

	If living – age/state of health	If deceased – age/cause of death
Father	________________________	____________________________
Mother	________________________	____________________________
Brother and Sisters	________________________	____________________________

Have either your mother or any sisters developed heart disease before age 65? Yes or No
Have either your father or any brothers developed heart disease before age 55? Yes or No

SOCIAL HISTORY:

Marital Status: _______________ Children:____
Occupation: ____

HABITS:

Smoking Do you smoke? Yes or No If yes, how many packs per day__________
If no, did you ever smoke? Yes or No If yes, # of years_____

Alcohol	How much per day? _________	How long? __________
Coffee	How much per day? _________	How long? __________
Tea	How much per day? _________	How long? __________
Soft Drinks	How much per day? _________	How long? __________

Do you exercise? Yes or No If yes, what kind of exercise and how much? _______________________

REVIEW OF SYSTEMS:

Have you ever had temporary blindness or double vision?	Yes	No
Do you suffer from nosebleeds?	Yes	No
Do you suffer from shortness of breath?	Yes	No
Do you suffer from chronic coughing or wheezing?	Yes	No
Have you ever coughed up blood?	Yes	No
Have you ever experienced chest pain or chest tightness? Date:______	Yes	No
Do you have palpitations (skipping or racing heartbeat)?	Yes	No
How many pillows do you use to sleep on and why? ______ for comfort_____? for breathing_______?		
Do you have problems with constipation?	Yes	No
Do you have problems with diarrhea?	Yes	No
Have you ever passed black, tarry bowel movements?	Yes	No
Do you have difficulty swallowing?	Yes	No
Have you ever had blood in your urine?	Yes	No
Do you have difficulty in urinating?	Yes	No
Do you have pain or burning upon urination?	Yes	No
Have you recently experienced unusual anxiety or stress?	Yes	No
Have you ever had vertigo (severe dizziness)?	Yes	No
Have you ever passed out?	Yes	No
Do you suffer from migraines or frequent headaches	Yes	No
Have you ever had seizures or tremors?	Yes	No
Do your feet and ankles swell?	Yes	No
Do you have leg pain when you walk?	Yes	No
Do you have any form of arthritis?	Yes	No
Do you have any ulcers on your feet?	Yes	No
Have you had recent unexplained weight loss or weight gain?	Yes	No
Have you had recent fever or shaking chills?	Yes	No

Patient signature: _______________________________________ Date:_______________

Physician Signature: _____________________________________ Date:_______________