Waco Cardiology Associates Information Sheet

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

Patient Information

Name: _____ _____ _____

Last First Middle

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

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

Address: _____

_____ _____ _____

City State Zip

Primary: (_____)_____-_____ Home Cell Work Secondary: (_____)_____-_____ Home Cell Work

Email Address: _____

Primary Care Provider: _____ Phone: (_____)_____-_____

How did you hear about Waco Cardiology? ____Family Dr. ____ Other Dr. ____ Other _____

Employer: _____ Phone: (_____)_____-_____

Marital Status:_____ Spouse's Name: _____

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

Is Patient in Hospice: Y N Is Patient in a Skilled Nursing Facility?: Y N

Name of Emergency Contact: _____ Relationship: _____

Address: _____ Phone: (_____)_____-_____

Insurance/Guarantor Information

Insurance Policy Holder (if different from patient):

Name: _____ DOB: _____ Relationship:_____

Address: _____ Phone: (_____)-_____-_____

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.

I understand my 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.

By signature below, I acknowledge that the Waco Cardiology Associates Notice of Privacy Practices has been made available to me. I understand that this document explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient's Signature: _____Date: _____

WCA NEW PATIENT EVALUATION-

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			
Thytroid			
Hyperlipidemia (high cholesterol, high trigycerides)			
Other:			

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

SURGERIES	YES	NO	COMMENTS

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 SYMPTOMS	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			
	Pain in legs with walking			
	Swelling in feet			
CONST	Weight gain			
	Weight loss			
	Fatigue			
HEENT	Vision changes			
	Hearing loss			
	Headache			
RESP	Wheezing			
	Blood in sputum			
	Difficulty breathing			
GI	Nausea			
	Reflux/Heartburn			
	Blood in Stools			
ALLERGIES				

	ROS continued	YES	NO	COMMENT
GU	Blood in urine			
	Frequent urination at night			
	Voiding large amounts of urine			
	Use of birth control pills			
	Erectile dysfunction			
NEURO	Dizzy/Lightheaded			
	Fainting			
	TIA ("mini stroke")			
HEM	Anemia			
	Easy bruising or bleeding			
ENDO	Heat intolerance			
	Cold intolerance			
	Tremors			
M/S	Joint pain			
	Muscle pain			
MOOD	Depression			
	Hallucinations			
	Anxiety			

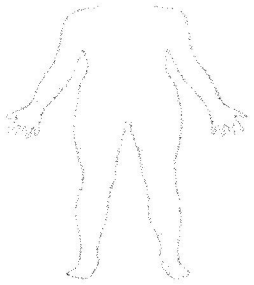
_____

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