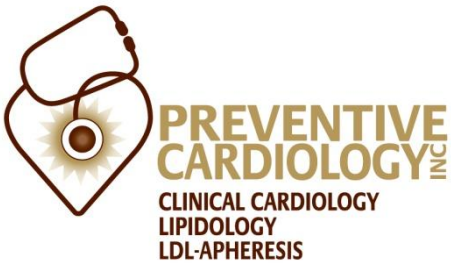


Seth J Baum, MD, FACC, FACPM, FAHA, FNLA

7900 Glades Road, Suite 400 Boca Raton, FL 33434

Phone 561.488.5535 -- Fax 561.488.2150

www.preventivecardiologyinc.com

Email: Lipids@preventivecardiologyinc.com

WELCOME TO OUR OFFICE

What is your name? _____ How old are you? _____

Date of Birth? _____ Married/Single? _____Male/Female? _____

Hispanic/Non-Hispanic_____ # of children_____ # of grandchildren_____

Address_____

_____ SS#_____

Home Phone_____ Cell_____ Email_____

Alternate Address/Phone_____

_____

Emergency Contact Name/Number_____

How did you hear about us? _____

Who is your primary doctor? _____

Primary Insurance carrier_____ ID Number_____

PREVENTIVE CARDIOLOGY INC
CLINICAL CARDIOLOGY
LIPIDOLOGY
LDL-APHERESIS

Dear Patient:

In order to assist us in obtaining an accurate history of your medical condition, please answer the following questions:

What medications or nutritional supplements are you allergic to or do you have intolerance to? _____

_____

Cardiovascular Risk Factors: Please check all that apply and describe:

- Cigarette smoking (if yes, how many packs per day, for how long, and when did you quit) _____
- Hypertension (BP >140/90 mm Hg or on antihypertensive medication)
  _____
- Low HDL cholesterol (< 40 mg/dl for men or <50 mg/dl for women)
- Family history of premature Coronary Heart Disease (CHD) that includes:
  CHD in male first-degree relative <55 years of age
  CHD in female first-degree relative <65 years of age
- Age (Men > 45 years, Women > 55 years)
- Autoimmune disorder (such as Rheumatoid Arthritis or Lupus)
  _____
- Pregnancy History of:
  - Hypertension
  - Diabetes
  - Spontaneous preterm delivery
  - Pre-Eclampsia or Eclampsia
  - Small for gestational age baby

Cardiovascular Risk Equivalents, Including: Please check all that apply:

- Peripheral arterial disease
- Abdominal aortic aneurysm
- Transient ischemic attacks or stroke of carotid origin
- ≥50% obstruction of a carotid artery
- Diabetes Mellitus

Do you have a history of any cholesterol abnormality? This includes a high LDL, a low HDL, or a high triglyceride level.

_____

Please describe your exercise regimen including the frequency, duration, type, and intensity of exercise.

_____

_____

_____

Please describe your typical diet in detail. Include snacks, desserts, soft drinks, and the quantity of water you drink.

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Water_____

Soft drinks_____

How much alcohol do you drink? Please describe the type of beverage, frequency of beverage, and number of drinks per week.

_____

Past Medical History: Have you ever had? Please check all that apply.

- Stroke
- Mini stroke (TIA)
- Claudication
- Heart attack
- Stent or angioplasty
- Bypass surgery
- An aneurysm
- Cardiomyopathy
- Valvular heart disease
- Shortness of breath with exertion
- Shortness of breath at rest
- Shortness of breath that awakens you from sleep
- A fainting spell
- A heart rhythm disturbance
- Palpitations
- An ablation
- Ulcer disease
- Diverticulitis
- Hiatal hernia
- GERD
- Irritable bowel syndrome
- Liver problems
- Hepatitis
- Any other gastrointestinal problem
- Osteoporosis
- Osteopenia
- Thyroid disease
- Low testosterone
- Low vitamin D
- Hormone replacement therapy
- Skin disorders
- Skin cancer
- Cancer (please describe)
- A blood disorder
- Asthma
- Pneumonia
- Bronchitis
- COPD
- A CT scan with contrast (dye)
- An MRI
- An echocardiogram
- A carotid ultrasound
- A Holter monitor
- A stress test
- A cardiac catheterization
- An angioplasty or stent

Past Surgical History:

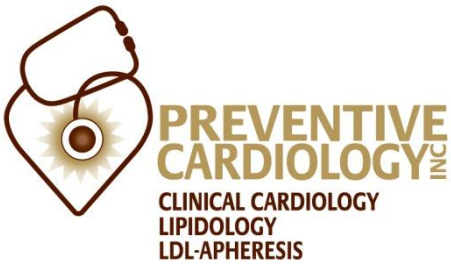
Please list any surgical procedures you have had with the date and location.

_____
_____
_____
_____
_____

Medications and Nutritional Supplements:

Please list all medications and nutritional supplements including their doses.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____



EXPLANATION OF PRACTICE POLICY REGARDING PAYMENT FOR SERVICES

MEDICARE PATIENTS:

ALL MEDICARE CLAIMS ARE SUBMITTED ELECTRONICALLY TO MEDICARE FOR YOU. **PATIENTS ARE RESPONSIBLE FOR ANY DEDUCTIBLES**. CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAID DIRECTLY BY YOUR SECONDARY CARRIER. ANY SUBSEQUENT BALANCE DUE AFTER CLAIMS ARE PROCESSED WITH YOUR SECONDARY CARRIER IS DUE IN FULL UPON RECEIPT.

CANCELLATION OF ANY SCHEDULED APPOINTMENT MUST BE MADE **AT LEAST** 24-HRS IN ADVANCE OR A **CANCELLATION FEE** WILL APPLY.

Full Name_____ (please print)

Signature_____ Date_____

NON-MEDICARE PATIENTS:

WE **DO NOT** CONTRACT WITH PRIVATE INSURANCE THEREFORE **PAYMENT IS DUE** IN FULL **AT THE TIME OF SERVICE**. IF YOU HAVE PROVIDED YOUR INSURANCE INFORMATION WE WILL BE HAPPY TO SUBMIT THE CLAIM FORM FOR YOU.

APPOINTMENTS WITH THE DOCTOR MUST BE CANCELLED **AT LEAST** 24-HRS IN ADVANCE OR **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL**.

Full Name_____ (please print)

Signature_____ Date_____

PREVENTIVE CARDIOLOGY INC
CLINICAL CARDIOLOGY
LIPIDOLOGY
LDL-APHERESIS

RECORDS RELEASE AUTHORITY

To:

_____

_____

_____

(Please print Doctors Name and address and # in the space provided above)

I, _____, hereby request that you release a report of my evaluation, diagnosis, and treatment including blood work and other pertinent test results

To:

Seth J Baum, MD, FACC, FACPM, FAHA, FNLA

7900 Glades Road, Suite 400 Boca Raton, FL 33434

Phone 561.488.5535 -- Fax 561.488.2150

www.preventivecardiologyinc.com

Email: reception@preventivecardiologyinc.com

Patient Name (printed)_____Date of Birth_____

Signature_____Date of Request_____