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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 _____

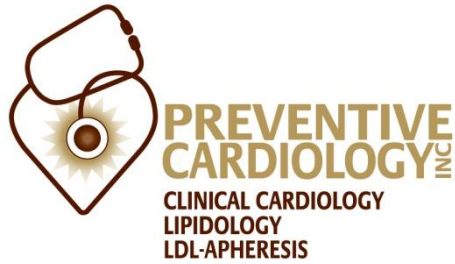
Alternate Address/Phone _____

Emergency Contact Name/Number _____

How did you hear about us? _____

Who is your primary doctor? _____

Primary Insurance carrier _____ ID Number _____



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
- $\geq 50\%$ 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

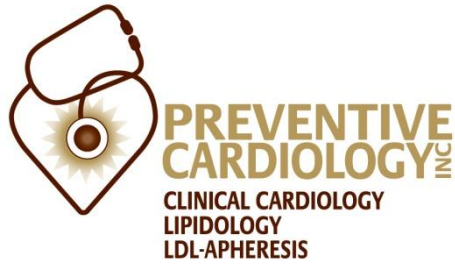
Past Surgical History:

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** _____

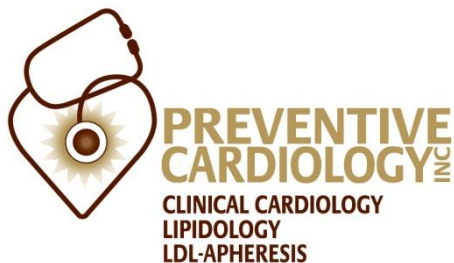
NON-MEDICARE PATIENTS:

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** _____



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:

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Patient Name (printed) _____ Date of Birth _____

Signature _____ Date of Request _____