



West Chester Cardiology
www.westchestercardiology.com

Mian A. Jan, MD, FACC, FSCAI
Hope Helfeld, DO, FACC
Zainal M. Hussain, MD
Paula Eryazici, MD
Ramprasad Gadi, MD
Leeann Parton, MS, PA-C
Samantha McLaughlin, MS, PA-C
Samantha Young, MS, PA-C
Anthony B. Krasnick, Office Manager

PATIENT INFORMATION

DATE: _____

DEMOGRAPHICS:

Name _____ D.O.B.: _____

Male / Female (circle one)

Street _____ City _____ State _____ ZIP _____

Social Security # _____ Marital Status _____ Home Phone _____

Employer _____ Daytime Phone _____

How were you referred to this practice? _____

Primary Care Physician _____

Physician's address _____ Phone _____

FOR COLLEGE STUDENTS ONLY

Name of College _____ Phone _____

College Residence Address _____

INFORMATION RELEASE (Please Note: We cannot submit insurance forms for you without your signature).

For all patients

In an Emergency, list the names and phone numbers of two people we can contact.

Name _____ Phone _____

Name _____ Phone _____

AUTHORIZATION FOR RELEASE OF INFORMATION

For all patients

I hereby authorize of information as well as payment to West Chester Cardiology, P.C.

Signature of Insured/Responsible Person

Date

CHIEF COMPLAINT:

List the reasons for your visit today in order of importance to you.

1. _____

2. _____

3. _____

4. _____



HISTORY OF PRESENT ILLNESS:

Write a brief chronological account of the illnesses that bring you in today. Continue on the back of the page if necessary.

PAST MEDICAL HISTORY:

Have you ever had or do you now have any of the following: (Circle only the ones pertaining to you).

- | | | |
|-------------------------------------|---------------------|-----------------------------|
| Mitral Valve Prolapse/Valve Disease | Lyme Disease | Kidney Disorder |
| Rheumatic Fever | Diabetes | Stomach Ulcers |
| High Cholesterol | High Blood Pressure | Heart Disease |
| Stroke/TIA | Bleeding Disorder | Peripheral Vascular Disease |

Other illnesses not listed above. Exclude usual childhood diseases unless complicated.

DURING THE LAST SIX MONTHS HAVE YOU:

- Lost or gained weight? (circle one) NO YES
- Been persistently tired..... NO YES
- Had chills or fever..... NO YES
- Been nervous or easily upset NO YES
- Been unable to sleep well NO YES
- Been depressed, sad or unhappy NO YES

DURING THE PAST YEAR, HAVE YOU HAD:

- Persistent or severe headaches NO YES
- Dizziness NO YES
- Eye trouble NO YES
- Hearing trouble..... NO YES
- Nosebleeds NO YES
- A sore in your mouth or tongue NO YES

DO YOU HAVE:

- Shortness of breath NO YES
- Chest pain or tightness NO YES
- Asthma or wheezing NO YES
- Persistent cough NO YES
- Blood spitting NO YES
- Swollen legs or feet NO YES
- Irregular or rapid heart beat NO YES
- Palpitations NO YES
- Passing out/loss of consciousness NO YES
- Pacemaker NO YES
- Defibrillator NO YES

HAVE YOU EVER HAD:

- Heart trouble (or coronary) NO YES
- High blood pressure NO YES
- A stroke NO YES
- An abnormal chest x-ray NO YES
- An abnormal EKG..... NO YES
- Kidney trouble NO YES
- Yellow jaundice, hepatitis or liver trouble NO YES

DO YOU HAVE:

- Burning or pain when you urinate NO YES
- Trouble passing urine NO YES
- Urinate frequently at night NO YES
- Blood in urine NO YES
- Back pain NO YES
- Stiff neck NO YES
- Painful or stiff joints NO YES
- Pain in your legs NO YES
- Cold feet and legs NO YES
- Phlebitis or varicose veins NO YES

DO YOU HAVE:

- Poor appetite NO YES
- Trouble swallowing NO YES
- Pains in stomach NO YES
- Belching or gas NO YES
- Heartburn NO YES
- Constipation NO YES
- Diarrhea NO YES
- Swollen Abdomen NO YES
- Blood in stools/black stools NO YES

FOR FEMALES ONLY:

- Have you stopped menstruating NO YES
- Are your periods abnormal NO YES
- Is there a possibility that you may be pregnant? NO YES
- Are you currently nursing? NO YES

Date of last internal exam (PAP) _____

Date of last menstrual period _____



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SERIOUS INJURIES OR ACCIDENTS:

PAST SURGICAL/PROCEDURE HISTORY:

CARDIAC CATHETERIZATION

Hospital: _____

Physician: _____

Date: _____

TYPE OF SURGERY:

Hospital: _____

Physician: _____

Date: _____

CARDIAC / ANGIOPLASTY

Hospital: _____

Physician: _____

Date: _____

TYPE OF SURGERY:

Hospital: _____

Physician: _____

Date: _____

OPEN HEART / BYPASS SURGERY

Hospital: _____

Physician: _____

Date: _____

TYPE OF SURGERY:

Hospital: _____

Physician: _____

Date: _____

MEDICATIONS:

List all medications/herbal supplements with dose and frequency:
Please continue list on the back of the page if necessary.

	Medication/Supplement	Dose	Frequency	Prescribing Physician
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO YES If yes, please list:



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FAMILY HISTORY:

	Age	Living/Deceased	Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

IS THERE A HISTORY IN YOUR FAMILY OF:

- DiabetesNO YES
- Heart attack.....NO YES Was family member less than 55 years old? NO YES
- Stroke.....NO YES Was family member less than 55 years old? NO YES
- Cancer or leukemiaNO YES
- TuberculosisNO YES
- Nervous Breakdown.....NO YES
- Blood disorder.....NO YES
- Sudden Cardiac Death.....NO YES

SOCIAL HISTORY:

Occupation _____

Married or single _____

Number of children _____

Cigarettes (pack per day) _____ When did you quit? _____

Caffeinated Beverages (per day) _____

Alcoholic beverages (per day) _____

Do you exercise regularly _____ Describe _____

FOR MEDICARE PATIENTS ONLY:

I hereby request the payment of authorized Medicare benefits to be made either to me or on my behalf to West Chester Cardiology, P.C. for any services furnished. I authorize West Chester Cardiology, P.C. to release my medical records to the Health Care Financing Administration to determine these benefits or the benefits payable to related services.

Signature

Medicare #

Date