West Chester Cardiology

www.westchestercardiology.com

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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. ____

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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:

Diabetes ....NO 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 leukemia ....NO YES

Tuberculosis ....NO 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