Cardiology and Vascular Associates, P.C.®

A Division of MHP Michigan Healthcare PROFESSIONALS

Authorization for the Communication of Medical Information

Patient Name:_____ Date of Birth:_____

Please contact me at the following numbers:

- Primary Number _____ Home Cell Other _____

  Can we leave you a detailed message at this number? YES NO

- Secondary Number _____ Home Cell Other _____

  Can we leave you a detailed message at this number? YES NO

I would like to have my test results: (Choose one)

____ called to my primary number

____ sent to my patient portal

____ called to _____ at the following number _____

I give permission to discuss all of my health information, including test results, to the following family members, friends, or caregivers. These people are to be called in order, in the event of an emergency.

- Name _____ Relationship _____

  Primary Number _____ Secondary Number _____

- Name _____ Relationship _____

  Primary Number _____ Secondary Number _____

- Name _____ Relationship _____

  Primary Number _____ Secondary Number _____

- I do not want my health information discussed with my family, but in the event of an emergency please contact _____ my _____ at the following number _____.

Patient Signature:_____ **Date:**_____

ACKNOWLEDGMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I read and/or took receipt of a copy of the Michigan Healthcare Professionals, P.C. Patient Notice of Privacy Practices (effective September 23, (2013).

Patient Name:_____ **Date of Birth:**_____

Signature:_____ **Date:**_____

Patient Questionnaire

Welcome to our cardiology practice! Please take a few moments to complete this medical history questionnaire to help us care for you. If you are unable to complete this form, kindly pass it to the medical assistant who accompanies you to your exam room, and we will be glad to help you. Thank you,

NAME: _____ DATE:_____

D.O.B.:_____ Provider you are seeing:_____

Emergency Contact, their phone number, and their relation to you:

_____

Current medication and their dosages:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Any known drug allergies? No Yes Iodine allergy? No Yes

Any other allergies: _____

_____

_____

_____

Cardiovascular Information

CHEST PAIN? YES _____ NO _____

If yes, please indicate the type:

Tightness/heaviness _____ Ache/numb/burning _____

Discomfort sensation _____

Location: Chest _____ Shoulder_____ Mid/Upper Back _____

Neck_____ Arm(s) _____

How long have you had this pain? _____ How often? _____

How long does it last? _____ How severe (0-10) is it? _____

Are your symptoms associated with activity? _____

Does anything make it worse or better? _____

Does the pain/discomfort radiate? _____ If so, where? _____

Shortness of Breath

No: _____ Yes: _____ -> How long has this been occurring? _____

How Often? _____ How long does it last? _____

How severe (mild, moderate, severe) is it? _____

Are symptoms associated with certain activities? _____

_____

Are you having or have you recently had any of the following problems?

Need to sit up to breathe?	Yes	No
Irregular heart beat/skipped beats?	Yes	No
Rapid heart beat/racing heart?	Yes	No
Lightheadedness?	Yes	No
Fainting spells?	Yes	No
Swelling in the legs?	Yes	No
Any type of past heart disease?	Yes	No
Have you been diagnosed with Angina?	Yes	No
Have you ever taken nitroglycerin?	Yes	No
Previous heart attack?	Yes	No
Rheumatic fever?	Yes	No
Heart murmur?	Yes	No

Other heart problem? No _____ Yes _____

_____

Chronic Illness

Do you have, or have you ever been diagnosed with:

Diabetes?	Yes	No
Hypertension/High blood pressure?	Yes	No
COPD?	Yes	No
Sleep apnea?	Yes	No
Asthma?	Yes	No
Heart Disease?	Yes	No

Please explain: _____

_____

_____

Past Medical History

Do you have, or have you ever been diagnosed with:

Cancer?	Yes	No
Stroke/Mini-stroke?	Yes	No
Arthritis?	Yes	No
Ulcers/reflux?	Yes	No
Thyroid disease?	Yes	No

Please explain: _____

_____

_____

_____

Family History

Has anyone in your immediate family had any major illnesses (heart disease, cancer, stroke, diabetes, hypertension, etc.)?

Please list: _____

_____

_____

_____

_____

Past Surgical History

Please list any past surgeries and dates: _____

_____

_____

_____

Have you ever had a heart catheterization? Yes No

If yes, at what hospital and approximately what date? _____

_____

_____

Have you ever had an angioplasty/stent? Yes No

If yes, at what hospital and approximately what date? _____

_____

_____

Have you had cardiac valve surgery? Yes No

If yes, at what hospital and approximately what date? _____

_____

Have you had heart bypass surgery? Yes No

If yes, at what hospital and approximately what date? _____

_____

Do you have a pacemaker? No _____ Yes _____ -> Year placed: _____

Do you have a defibrillator? No _____ Yes _____ -> Year placed: _____

Social History

Occupation: _____ Retired: _____

Employer: _____

Are you exposed to asbestos, chemicals, excessive noise, or toxins at your workplace? No ____

Yes _____

Have you ever smoked? No _____ Yes _____ How long? _____

How many packs per day? _____ Quit? _____

Do you/have you ever used illicit ("street") drugs? No _____

Yes -> type: _____

Do you drink alcohol? No _____ Yes _____

How often and how much, _____

Do you use birth control pills? No or N/A _____ Yes _____

Do you drink anything caffeinated? No _____ Yes _____

If yes, How much and how often per day? _____

Do you have any symptoms usually with your daily activities? No _____ Yes_____

If yes, Please describe _____

_____

Do you exercise? No _____ Yes _____ -> Please describe your routine

_____

General Symptoms or Problems

Are you having/have you had any of the following:

Significant weight change?	Yes	No
Chills or fevers?	Yes	No
Skin rashes?	Yes	No
Headaches?	Yes	No
Cough w/phlem for atleast 2 months each year?	Yes	No
Cough up blood?	Yes	No
Nausea/vomiting?	Yes	No
Diarrhea?	Yes	No
Constipation?	Yes	No
Bloody stool?	Yes	No
Abdominal pain or indigestion?	Yes	No
Difficulty in starting urinary stream?	Yes	No
Burning with urination?	Yes	No
Arthritis or join pain?	Yes	No
Heat or cold intolerance?	Yes	No
Hair loss?	Yes	No
Nervousness/anxiety?	Yes	No
Increased stress?	Yes	No
Depression?	Yes	No
Chest x-ray within the past 5 years?	Yes	No
Other: _____		
Loud snoring/stop breathing at night?	Yes	No
Daytime sleepiness?	Yes	No

_____

Medical records use only:

Abstracted by: _____

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ALL INFORMATION REQUESTED HERE IS REQUIRED IN ORDER TO PROPERLY BILL YOUR INSURANCE

DATE:_____ **DATE OF BIRTH:**_____ **AGE:**_____

NAME:_____ **SEX: M F**

STREET ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

MARITIAL STATUS: S M D W SPOUSE NAME:_____

SOCIAL SECURITY NUMBER:_____

HOME PHONE: (___)_____ **CELL PHONE:** (___)_____

(In providing my cell phone number I give you permission to contact me at this number.)

EMAIL ADDRESS:_____

OCCUPATION:_____ **EMPLOYER:**_____

EMPLOYER PHONE NUMBER: (___)_____

REFERRING PHYSICIAN:_____ **PHONE:** (___)_____

CITY:_____ **STATE:**_____ **ZIP:**_____

PRIMARY CARE PHYSICIAN:_____ **PHONE:** (___)_____

Insurance Subscriber

Please list the insurance subscriber (if subscriber is not patient)

SUBSCRIBER NAME:_____

SUBSCRIBER DATE OF BIRTH:_____

RELATIONSHIP TO PATIENT:_____

SUBSCRIBER SOCIAL SECURITY NUMBER:_____

PATIENT SIGNATURE:_____

Patient Name: _____

Date of Birth: _____

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For all patients:

Due to recent healthcare reform laws and meaningful use requirements, we are mandated to request the following information:

1) Ethnicity
2) Race
3) Primary language

Please provide the following information:

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black and/or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White and/or Caucasian
- ☐ More than one race
- ☐ Other. Please specify:_____

Primary Language:

_____

The above collected information is only seen by the practice's registration staff, administrators and personnel involved in quality control, improvement, and oversight.. The confidentiality of information provided herein is protected by law. This information is entered directly into our computer system as anonymous data and your name is not collected anywhere on this form. This form will be destroyed after data entry.

You have the right to refuse to disclose and/or provide the above requested information. This refusal will not affect your status as a patient or the care provided to you. If you so desire, please indicate such refusal below.

☐ I hereby decline to disclose the information requested on this form.

Thank you for your cooperation.

Patient Name:_____ Date of Birth:_____

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOU PREFERRED PHARMACY.

PRIMARY PHARMACY NAME:_____

PRIMARY PHARMACY ADDRESS:_____

PRIMARY PHARMACY PHONE NUMBER: (___)_____

PRIMARY PHARMACY FAX NUMBER: (___)_____

SECONDARY/MAIL PHARMACY NAME:_____

SECONDARY/MAIL PHARMACY ADDRESS:_____

SECONDARY/MAIL PHARMACY PHONE NUMBER: (___)_____

SECONDARY/MAIL PHARMACY FAX NUMBER: (___)_____

Patient Name:_____

Date of Birth:_____