

Patient Registration Form

Last Name _____		First Name _____		MI _____
Social Security ___ - ___ - ____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Additional gender category or other <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Female-to-Male (FTM)/Transgender <input type="checkbox"/> Genderqueer, neither excl male or female <input type="checkbox"/> Male-to-Female (MTF)/Transgender		Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Legally Sep <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Unknown <input type="checkbox"/> Married	
Date of Birth ___ / ___ / ____				
Address _____		City _____	State _____	Zip _____
Email _____				
Primary Phone (____) _____ - _____			Secondary Phone (____) _____ - _____	
Preferred Language _____				
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unknown/Decline to Answer		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Decline to Answer		
Responsible Party: This section refers to the person/party who should receive the bill				
Relationship to Patient <input type="checkbox"/> Self (skip this section) <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____				
Last Name _____		First Name _____		MI _____
Social Security ___ - ___ - ____	Date of Birth ___ / ___ / ____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Address _____		City _____	State _____	Zip _____
Primary Phone (____) _____ - _____			Secondary Phone (____) _____ - _____	



Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant verbal discussions regarding my health care. By signing this form, I permit Cardiology Consultants (CC) staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

- I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.
- I understand that information may be released to family members or others without this form, if allowed by federal and state law.
- I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.
- I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.
- I can update this form at any time by completing a new form and giving it to CC staff.
- I understand that CC staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.
- **I understand that this is *not* a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information.**

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Signature of Patient (or Parent/Legal Guardian if Patient is a Minor): _____

Printed Name of Patient: _____ DOB: _____

Date: _____

Relationship to Patient (if applicable): _____

PAST MEDICAL & SURGICAL HISTORY

<p><u>EENT</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cataracts <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Sinusitis <input type="checkbox"/> Tinnitus <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Other: _____ <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> ARDS (Adult Resp. Distress Syndrome) <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary Embolus (clot) <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Sleep Apnea, CPAP <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other: _____ <p><u>Cardiac</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Myocardial Infarction (heart attack) <input type="checkbox"/> Sudden Death <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Other: _____ <p><u>Vascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Aortic Aneurysm <input type="checkbox"/> Carotid Disease <input type="checkbox"/> Claudication <input type="checkbox"/> DVT <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Phlebitis <input type="checkbox"/> Raynaud's <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Other: _____ 	<p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> GERD <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other: _____ <p><u>Renal/GU</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> BPH (enlarged prostate) <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Prostatitis <input type="checkbox"/> Renal Artery Stenosis <input type="checkbox"/> Renal Failure <input type="checkbox"/> Renal Insufficiency <input type="checkbox"/> Other: _____ <p><u>GYN</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Benign Breast Lump <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Other: _____ <p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Back Pain <input type="checkbox"/> Gout <input type="checkbox"/> Lupus <input type="checkbox"/> MVA Trauma <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other: _____ <p><u>Skin</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cellulitis <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Other: _____ 	<p><u>Neurologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> CVA <input type="checkbox"/> Dementia <input type="checkbox"/> Diabetic Neuropathy <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Syncope <input type="checkbox"/> TIA <input type="checkbox"/> Other: _____ <p><u>Psychiatric</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anorexia <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Chronic Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Post-Traumatic Stress Disorder <input type="checkbox"/> Other: _____ <p><u>Hematologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Other: _____ <p><u>Endocrine</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid <input type="checkbox"/> Other: _____ <p><u>Infectious Disease</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Endocarditis <input type="checkbox"/> HIV <input type="checkbox"/> Other: _____ <p><u>Recent Hospitalizations</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>List Hospital/Date/Reason for hospitalization: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Cardiac Surgeries & Procedures

<input type="checkbox"/> Cardiac Cath	Year _____
<input type="checkbox"/> Cardioversion	Year _____
<input type="checkbox"/> Coronary Angioplasty/Stent	Year _____
<input type="checkbox"/> Coronary Artery Bypass	Year _____
<input type="checkbox"/> EP Study	Year _____
<input type="checkbox"/> ICD Placement	Year _____
<input type="checkbox"/> Pacemaker Implant	Year _____
<input type="checkbox"/> RF Ablation	Year _____
<input type="checkbox"/> Heart Valve Repair/Replaced	Year _____
<input type="checkbox"/> Other: (List Below)	Year _____

Other Surgeries & Procedures

<input type="checkbox"/> Aneurysm Repair	Year _____
<input type="checkbox"/> Appendectomy	Year _____
<input type="checkbox"/> Back surgery	Year _____
<input type="checkbox"/> Carotid Surgery	Year _____
<input type="checkbox"/> Cholecystectomy (Gallbladder removed)	Year _____
<input type="checkbox"/> Gastric Bypass	Year _____
<input type="checkbox"/> Hysterectomy	Year _____
<input type="checkbox"/> Kidney Stone Treatment	Year _____
<input type="checkbox"/> Knee Surgery	Year _____
<input type="checkbox"/> Mastectomy	Year _____
<input type="checkbox"/> Nephrectomy (Kidney removed)	Year _____
<input type="checkbox"/> Tonsillectomy	Year _____
<input type="checkbox"/> Thyroidectomy	Year _____
<input type="checkbox"/> Other: _____	Year _____

SOCIAL & FAMILY HISTORY

<p>Alcohol Use Do you consume alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Frequency: _____ Year quit: _____</p> <p>Smoking/Tobacco Use Do you smoke/use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Smokeless Number of years smoked: _____ Packs per day: _____ Years quit: _____ Passive Smoke Exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Diet Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No What type of diet? _____ Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No How much a day? _____ Do you eat much chocolate a day? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Exercise Do you exercise regularly? <i>(minimum of 30 minutes/3 times a week)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If YES describe: _____</p> <p>Religion: _____ Agree to Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Drug Use/Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Substance type: _____ Years quit: _____</p> <p>Marital Status: _____</p> <p>Occupation List: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired</p> <p>Residence Live with: _____ <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted Living</p> <p>Advanced Directives <input type="checkbox"/> None <input type="checkbox"/> DNR <input type="checkbox"/> HC Proxy <input type="checkbox"/> Living Will Date: _____</p>																												
<p>Is there a Family History of: (List All Family Members):</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">Heart Attack</td> <td style="width:10%;"><input type="checkbox"/></td> <td style="width:10%;"><input type="checkbox"/></td> <td style="width:50%;">Family Member _____</td> </tr> <tr> <td>Stroke</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family Member _____</td> </tr> <tr> <td>Coronary Bypass Surgery</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family Member _____</td> </tr> <tr> <td>Diabetes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family Member _____</td> </tr> <tr> <td>High Blood Pressure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family Member _____</td> </tr> <tr> <td>Coronary Artery Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family Member _____</td> </tr> <tr> <td>Sudden Death</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family Member _____</td> </tr> </table>			Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____	Coronary Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____	Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____	Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____
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Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>	Family Member _____																											

REVIEW OF SYSTEMS Check if you are experiencing any of the symptoms listed below.

<p>General <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weight change (Loss or Gain) <input type="checkbox"/> Night sweats <input type="checkbox"/> Fatigue</p> <p>HEENT <input type="checkbox"/> Headache <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nosebleeds</p> <p>Respiratory <input type="checkbox"/> Persistent cough <input type="checkbox"/> Shortness of breath with rest <input type="checkbox"/> Shortness of breath with activity <input type="checkbox"/> Snoring <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> # of pillows used to sleep on _____</p>	<p>Cardiovascular <input type="checkbox"/> Chest pain, pressure or tightness <input type="checkbox"/> Passing out <input type="checkbox"/> Heart palpitations <input type="checkbox"/> History of blood clots or phlebitis <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> Non-healing sores on legs or feet <input type="checkbox"/> Pain in legs/hips with walking <input type="checkbox"/> Shortness of breath lying flat <input type="checkbox"/> Swelling of feet or ankles <input type="checkbox"/> Waking up panicky & short of breath <input type="checkbox"/> Dizziness</p> <p>Gastrointestinal <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> Nausea without vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Heartburn/Indigestion <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Black tarry stools <input type="checkbox"/> Difficulty swallowing solids/liquids</p> <p>Endocrine <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Increased urination <input type="checkbox"/> Hair loss</p> <p>Hematological <input type="checkbox"/> Bleed easily <input type="checkbox"/> Bruise easily</p>	<p>Neurological <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness/tingling on one side <input type="checkbox"/> Weakness on one side <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Loss of memory</p> <p>Musculoskeletal <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Muscle cramps</p> <p>Genitourinary <input type="checkbox"/> Blood in urine <input type="checkbox"/> Pain with urination <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Urgency of urination <input type="checkbox"/> Incontinence</p> <p>Males: <input type="checkbox"/> Difficulty starting stream <input type="checkbox"/> Wake up at night to urinate <input type="checkbox"/> History of urinary retention <input type="checkbox"/> Prostate problems <input type="checkbox"/> Erectile dysfunction</p> <p>Females: Date of last menstrual period: _____ <input type="checkbox"/> Currently on Birth Control Menopause: <input type="checkbox"/> Yes <input type="checkbox"/> No Age at Menopause: _____</p>
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Signature of Patient (or Parent/Legal Guardian if Patient is a Minor): _____

Printed Name of Patient: _____ DOB: _____

Date: _____ Relationship to Patient (if applicable): _____