

Dear

Welcome to our practice. We appreciate the opportunity to provide your specialty care. Our staff is made up of well-qualified professionals who work together as a team to bring you the highest quality of treatment in a warm, caring setting.

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Your initial visit will be spent obtaining as much information as possible: personal, medical history, insurance information, etc. This may include lab test, diagnostic testing and physical examination. Please allow the entire day for this visit if possible. Listed below are a few steps to ensure your visit is informative and comfortable:

- Bring a **list of all current medications** with you, including over-the-counter medications, such as aspirin.
- Wear **comfortable clothing**.
- You may be required to bring any previous radiology testing or angiogram films with you the day of your appointment. You will be notified prior to your appointment if this is necessary. In the event this is required it is Very important to obtain this information as this could result in rescheduling of your appointment.
- You may want to bring a sack lunch to your appointment. We provide coffee and water however we do not have vending machines in the office.
- Bring your **insurance cards**. We will file insurance claims.
- **Complete the enclosed forms** and bring with you to our office. This information will be kept in your medical file.

If you are being seen:

- In Oklahoma City we are located at 3200 Quail Springs Parkway, Suite 200.
- In Kingfisher we are located at Kingfisher Clinic 1100 Hospital Cir.
- In Ardmore we are located at the Mercy Clinic (former Medical Arts) 921 14<sup>th</sup> Ave NW.
- In Weatherford we are located at the Bluth Specialty Clinic 1315 N. Washington Ave.

Should you have questions regarding your appointment please call Dr. Parsons's Oklahoma City office @ (405) 241-3538.

We look forward to seeing you.  
*Dr. Blake Parsons and Staff*



3200 Quail Springs Parkway, Ste. 200  
 Oklahoma City, OK 73134  
 (O) 405-701-9880  
 (F) 405-701-9881  
 cvhealthclinic.com

**New Patient History**

Date: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

What doctor referred you to our clinic? Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Pharmacy name, Location, and Phone Number \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**Allergies**

Are you allergic to any medications:  Yes  No Are you allergic to Iodine?  Yes  No

If YES, please list medication and reaction \_\_\_\_\_

**Social History**

Smoking Status

- Current Everyday  Former Smoker  Heavy Cigar/Pipe Smoker  
 Current Some Day Smoker  Never Smoker  Light Cigar/Pipe Smoker

Type of Tobacco

- Cigarettes  Chewing Tobacco  Smokeless Tobacco/Other  
 Cigars  Vapor/E-Cigarettes  Pipe  
 Snuff

Do you drink alcohol?  Yes  No If yes, how much?  0-1 drinks/day  1-2 drinks/day  over 3 drinks/day

Caffeine (coffee, tea, soda, energy drinks, etc.)  None  0-1 drinks/day  1-2 drinks/day  over 3 drinks/day

Do you use illicit drugs?  Never  Yes TYPE/FREQUENCY \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed

Are you employed?  Yes  No Is your work  Sedentary  Normal  Labor Intensive

Are you retired?  Yes  No

Do you exercise?  Yes  No If so what type and how often? \_\_\_\_\_



**Family History**

	Mother	Father	Brother/ Sister	Brother/ Sister	Brother/ Sister	Son/ Daughter	Son/ Daughter	Son/ Daughter
<b>Age</b>								
<b>If Deceased, Age at Death</b>								
<b>Cause of Death</b>								
<b>Check all that apply</b>	Arrhythmia							
	Coronary Artery Disease							
	Heart Attack							
	Abdominal Aortic Aneurysm							
	Heart Failure							
	Hyperlipidemia							
	Hypertension							
	Sudden Cardiac Death							
	Stroke							
	Asthma							
	COPD							
	Diabetes							
	Cancer							

**Medical History - have you ever had any of the following illnesses?**

	Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chest Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Disease/Blockage	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular Disease/Blockage	<input type="checkbox"/>	<input type="checkbox"/>	If you have sleep apnea, do you wear a CPAP?	<input type="checkbox"/>	<input type="checkbox"/>

**Previous Cardiac Testing**

	Yes	No	Date	Place
Ultrasound of Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stress Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart CT Scan (Calcium Score)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ultrasound of Legs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Surgical/Procedure History**

	Yes	No	Date	Place
Arteriogram (Cath)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Angioplasty (Balloon)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stent in the Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Open Heart Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pacemaker or Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Other surgeries or procedures - please list surgery and approximate date:**

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**Peripheral Vascular Disease**

Do you experience aching or cramping in your legs, thighs or buttocks when walking or exercising?  Yes  No

If yes, does the pain go away with rest?  Yes  No

Do you limit exercise due to leg cramps and/or pain?  Yes  No

Do you have numbness and tingling in your legs or feet?  Yes  No

Do you have open sores or ulcers on your leg(s) or feet that will not heal?  Yes  No

Do you suffer from varicose veins?  None  Some  Moderate  Severe

Do you suffer from spider veins?  None  Some  Moderate  Severe

Do you wear compression stockings?  None  Intermittent  Daily

**Review of Systems**

Please check any of the symptoms you have experienced in the last 30 days. Any unchecked boxes will be assumed to be negative. Please check here if you are not experiencing any of the below symptoms

**Constitutional**

- Fatigue
- Fever
- Insomnia
- Weight gain
- Weight loss

**Head/Neck**

- Headache
- Neck pain

**Eyes**

- Blurred vision
- Decreased vision
- Glaucoma
- Cataracts

**Ear, Nose, Mouth and Throat**

- Earache
- Nasal Congestion
- Sore throat
- Ringing in ears

**Cardiovascular**

- Chest pain
- Pain in legs with walking
- Decreased exercise tolerance
- Palpitation
- Awakened with breathing difficulty
- Difficulty breathing lying flat
- Swelling in your legs/feet

**Pulmonary**

- Cough
- Shortness of breath
- Snoring
- Sputum production
- Wheezing

**Gastrointestinal**

- Abdominal pain
- Constipation
- Diarrhea
- Heartburn
- Blood in stools
- Loss of appetite
- Nausea
- Vomiting

**Genitourinary**

- Pain on urination
- Urinary frequency
- Incontinence
- Frequent urination at night
- Urinary hesitancy

**Musculoskeletal**

- Back pain
- Foot pain
- Joint pain/stiffness
- Hip pain

**Neurologic**

- Confusion
- Lightheaded/Dizziness
- Loss of balance/coordination
- Slurred speech
- Passing out
- Weakness

**Psychiatric**

- Anxiety
- Depression

**PLEASE PRINT: Use black or blue ink only**

PATIENT INFORMATION										
<b>If this is work related, stop and notify receptionist</b>										
DATE:		Referring Physician & Phone Number:				Family Physician & Phone Number:				
<b>LEGAL NAME</b>	Last:			Suffix:		First:		Middle:		
	Preferred Name:					Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Address:					City:		State:	Zip:		
Birthdate: / /		Age:		Social Security # - -						
Home Telephone: ( )			Cell Phone: ( )			Work Phone & Ext: ( )				
Email:			May we contact you through Email: <input type="checkbox"/> Yes <input type="checkbox"/> No			Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D				
<b>Race:</b> <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Pacific Islander			<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Non-Latino		<b>Religion:</b>		<b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		<b>Interpreter Needed:</b> <input type="checkbox"/> Yes  <input type="checkbox"/> No	
Employer:		Address:			City:		State:	Zip:		
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Un-Employed <input type="checkbox"/> Military <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired										
Patient's Primary Contact (Not living in the same residence)				Contact Number: ( )			Relationship to Patient:			
SPOUSE/PARENT INFORMATION										
Spouse/Parent Information (if child under 18)			Relation to Patient:		Home Telephone: ( )		Cell Phone: ( )			
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Un-Employed <input type="checkbox"/> Military <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired										
Employer:		Social Security # - -			Birthdate: / /		Age:	Work Phone & Ext: ( )		
Address:				City:		State:	Zip:			
INSURANCE INFORMATION (Provide cards to copy)										
Primary Insurance:					<b>Insurance Type:</b> <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Cobra					
Insured's Name on Card:			I.D. #			Group #				
Insured's Birthdate: / /		Patient's Relation to Insured:		Insured's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Insured's SS # / /				
Secondary Insurance:					<b>Insurance Type:</b> <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Cobra					
Insured's Name on Card:			I.D. #			Group #				
Insured's Birthdate: / /		Patient's Relation to Insured:		Insured's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Insured's SS # / /				
HOW DID YOU HEAR ABOUT US?										
<input type="checkbox"/> Physician Referral <input type="checkbox"/> Family/Friend <input type="checkbox"/> Radio <input type="checkbox"/> Social Media <input type="checkbox"/> Billboard <input type="checkbox"/> Google Search <input type="checkbox"/> Health Fair <input type="checkbox"/> Other: _____										
I authorize the release of information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims made payable to Cardiovascular Health Clinic. I understand I am financially responsible for any changes not covered by my insurance.										
_____					_____					
Patient or Authorized Person					Date					



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**Release of Protected Health Information to Family Members and Persons Involved in Patient's Care**

With your permission, CardioVascular Health Clinic may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, CardioVascular Health Clinic may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or procedure or provide the person with a copy of a prescription. Pharmacies will also be notified or sent a list of your medications if required for the continuance of care. By completing the top portion of this form, you are authorizing CardioVascular Health Clinic to release this information to these individuals. However, you are not authorizing CardioVascular Health Clinic to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate HIPAA authorization form. Please be aware that CardioVascular Health Clinic may use its professional judgement in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name	Relationship

**Authorization to Leave Voice Mail and Email Messages**

CardioVascular Health Clinic is required to have your permission to leave voice messages or send email messages regarding your Protected Health Information (test results, instruction, etc.) Please check the appropriate boxes:

- Yes, CardioVascular Health Clinic may leave a message on my answering machine/voice mail regarding my Protected Health Information.
- No, CardioVascular Health Clinic may not leave a message on my answering machine/voice mail regarding my Protected Health Information.
- .....
- Yes, CardioVascular Health Clinic may email me a message regarding my Protected Health Information.
- No, CardioVascular Health Clinic may not email me a message regarding my Protected Health Information.

***I understand that if I change my mind about any of the information in this form, I must contact CardioVascular Health Clinic to revoke this form in its entirety or to complete a new form.***

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Today's Date

\_\_\_\_\_  
 Print Patients Name

\_\_\_\_\_  
 Verbally Taken by (CHC Employee)

\_\_\_\_\_  
 Patient Date of Birth

\_\_\_\_\_  
 Witness (CHC Employee)

**Advance Directive Questionnaire**

- I currently have an Advance Directive (aka Living Will) in place.
- Structured Decision Maker (aka Power of attorney) has been assigned.
- I understand that it is the policy of this Facility that a patient's Do-Not-Resuscitate consent or order is suspended while such patient is at this facility. The policy of this facility is that efforts will be made until such time the patient can be transferred to a Hospital emergency room. At that time care will be transferred to the attending Emergency room physician.
- DOES NOT APPLY

Pharmacy Name: \_\_\_\_\_

Pharmacy Location: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**To be completed by Office Staff:**

CHC Employee: \_\_\_\_\_

Date: \_\_\_\_\_