

Welcome to our practice. We appreciate the opportunity to provide your cardiovascular 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.

Your initial visit will be spent obtaining as much information as possible: personal, medical history, insurance information, etc. This may include an electrocardiogram, lab work, examination, and possible diagnostic tests. 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.
- Nothing to eat and only plain water for 4-6 hours prior to your appointment. No caffeine after midnight.
- 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 Woodward we are located at 1810 Kansas Ave., Woodward, OK 73801.
- In Weatherford we are located at the Bluth Specialty Clinic 1315 N. Washington Ave.
- In Pauls Valley we are located at Pauls Valley Clinic 415 W. Guy, Pauls Valley, OK 73075

We look forward to seeing you!

CardioVascular Health Clinic



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
Age								
If Deceased, Age at Death								
Cause of Death								
Check all that apply	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"/>	_____	_____

Patient Name: _____ **DOB:** _____

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

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									
If this is work related, stop and notify receptionist									
DATE:		Referring Physician & Phone Number:				Family Physician & Phone Number:			
LEGAL NAME	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			
Race: <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			Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Non-Latino		Religion:		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		Interpreter Needed: <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:					Insurance Type: <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:					Insurance Type: <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: _____