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

CARDIOVASCULAR HEALTH CLINIC
ADVANCED INTERVENTIONAL RADIOLOGY SOLUTIONS

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? _____

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Medications

List any medications you are currently taking, including over the counter medications.

Name	Dosage	Frequency

Patient Name:_____ DOB:_____

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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	☐	☐	Stroke	☐	☐
Chest Discomfort	☐	☐	Hepatitis	☐	☐
Heart Attack	☐	☐	Stomach Ulcers	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	Emphysema	☐	☐
Tuberculosis	☐	☐	Arthritis	☐	☐
Kidney Disease	☐	☐	AIDS	☐	☐
Thyroid Disease	☐	☐	Cancer	☐	☐
Elevated Cholesterol	☐	☐	Phlebitis	☐	☐
Carotid Disease/Blockage	☐	☐	Sleep Apnea	☐	☐
Peripheral Vascular Disease/Blockage	☐	☐	If you have sleep apnea, do you wear a CPAP?	☐	☐

Previous Cardiac Testing

	Yes	No	Date	Place
Ultrasound of Heart	☐	☐		
Stress Test	☐	☐		
Hearth CT Scan (Calcium Score)	☐	☐		
Ultrasound of Legs	☐	☐		

Surgical/Procedure History

	Yes	No	Date	Place
Arteriogram (Cath)	☐	☐		
Angioplasty (Balloon)	☐	☐		
Stent in the Heart	☐	☐		
Open Heart Bypass Surgery	☐	☐		
Heart Valve Replacement	☐	☐		
Pacemaker of Defibrillator	☐	☐		

Patient Name:_____ DOB:_____

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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

Patient Name:_____ DOB:_____

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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: ☐ Male ☐ Female	
Address:		City:	State:	Zip:
Birthdate: / /	Age:	Social Security # - -		
Home Telephone: ( )	Cell Phone: ( )		Work Phone & Ext: ( )	
Email:	May we contact you through Email: ☐ Yes ☐ No		Marital Status: ☐ S ☐ M ☐ W ☐ D	

Race:	**Ethnicity:**	**Religion:**	**Language:**	**Interpreter Needed:**
☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Other ☐ Pacific Islander	☐ Hispanic or Latino ☐ Non-Hispanic ☐ Non-Latino		☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No

Employer:	Address:	City:	State:	Zip:

Employment Status: ☐ Full-time ☐ Full-Time Student ☐ Un-Employed ☐ Military ☐ Self-Employed ☐ 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: ☐ Full-time ☐ Full-Time Student ☐ Un-Employed ☐ Military ☐ Self-Employed ☐ Retired

Employer:	Social Security # - -	Birthdate: / /	Age:	Work Phone & Ext: ( )
Address:	City:	State:	Zip:	

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance:			**Insurance Type:** ☐ Group ☐ Individual ☐ Cobra
Insured's Name on Card:	I.D. #	Group #	
Insured's Birthdate: / /	Patient's Relation to Insured:	Insured's Gender: ☐ Male ☐ Female	Insured's SS # / /

Secondary Insurance:			**Insurance Type:** ☐ Group ☐ Individual ☐ Cobra
Insured's Name on Card:	I.D. #	Group #	
Insured's Birthdate: / /	Patient's Relation to Insured:	Insured's Gender: ☐ Male ☐ Female	Insured's SS # / /

HOW DID YOU HEAR ABOUT US?

☐ Physician Referral ☐ Family/Friend ☐ Radio ☐ Social Media ☐ Billboard ☐ Google Search ☐ Health Fair ☐ 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) _____

CARDIOVASCULAR HEALTH CLINIC

ADVANCED INTERVENTIONAL RADIOLOGY SOLUTIONS

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: _____