FLORIDA CARDIAC CONSULTANTS, INC.

Patient's Personal Information Date:_____

Confidential Record: Information contained here will be used according to our Privacy Practice Notice

Patient's Full Legal Name:

_____

(First) (Middle) (Last)

Address:_____ Cell#:_____

_____ Email:_____

Northern Address (if applicable): Dates at Northern Address:

_____ _____

_____

Male__ Female__ SS#_____ Marital Status (circle one): S M D W

Date of Birth:_____ Spouse's Name:_____

Employer:_____

Emergency Contact:_____ Contact Phone Number:_____

Relationship of Contact to Patient:_____

Family/PCP Physician:_____

(First name) (Last name)

Family/PCP Address:_____

Requesting Physician:_____

INSURANCE INFORMATION

Primary Insurance Company/Address:_____

Policy/Subscribers Name:_____ DOB_____ Relationship_____

Group/ID Number:_____

Secondary Insurance Company/Address:_____

Policy/Subscribers Name:_____ DOB_____ Relationship_____

Group/ID Number:_____

Worker's Compensation:_____ W/C #_____

Original Date of Injury:_____

Patient's Name:_____ DOB_____

REASON FOR CONSULTING CARDIOLOGIST:_____
_____
PRIMARY CARE PHYSICIAN:_____
PREVIOUS CARDIOLOGIST:_____
NAME/SPECIALTY OF CURRENT PHYSICIANS:_____

PAST HISTORY:

Have you ever been to the hospital for cardiac issues? ____ When _____ Where_____

Have you ever had?	If so, approximate date	Have you ever had?	If so, approximate Date
Jaundice/liver issues	_____	Heart Murmur	_____
Asthma or COPD	_____	Fam. History Heart Disease	_____
Tuberculosis	_____	Hypertension	_____
Epilepsy	_____	High Cholesterol	_____
Anemia	_____	Last Cholesterol check	_____
Thyroid Disorder	_____	History of Smoking	_____
Stroke/mini-stroke	_____	Congestive Heart Failure	_____
Peripheral Vascular Dis.	_____	Heart Attack	_____
Kidney problems	_____	Atrial Fibrillation	_____
Cancer	_____	Coronary Artery Dis.	_____
Blood Clots	_____	Abnormal Heart Rhythm	_____
Diabetes	_____	Weakened Heart Muscle	_____
Sleep Apnea	_____		

SURGICAL

Operations:	Approximate Year:		Approximate Year:
Bypass Valve	_____	Watchman	_____
Angioplasty/Stent	_____	TAVR	_____
Heart Cath/Angiogram	_____	Other Operations	_____
Tonsillectomy	_____	Defibrillator (model)	_____
Appendectomy	_____	Pacemaker (model)	_____
Hysterectomy	_____		
Orthopedic	_____		

Do You have a DNR? Yes___ No ___

FAMILY HISTORY:

	If living – age/state of health	If deceased – age/cause of death
Father	_____	_____
Mother	_____	_____
Brother and Sisters	_____	_____

Have either your mother or any sisters developed heart disease before age 65? Yes or No
Have either your father or any brothers developed heart disease before age 55? Yes or No

Patient's Name:_____ DOB_____

Preferred Pharmacy:_____ **Mail Order** (if applicable):_____
(Name and City)

MEDICATIONS: Please list below the medications you are currently taking, including non-prescription medications and vitamins.

Name of Medication	Dosage	How many times per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You take Aspirin? Yes___ No___

ALLERGIES:
Please list all allergies that you may have. This would include allergies to any medications, iodine/dyes, foods, pollens, etc. and **include the reaction**:_____
_____
_____

SOCIAL HISTORY:
Marital Status: _____ Children:_____ Occupation:_____

HABITS:
Smoking Do you smoke? Yes or No If yes, how many packs per day_____

If no, did you ever smoke? Yes or No If yes, # of years_____ Year started_____ Year stopped_____

Alcohol	How much per day? _____	How long? _____
Coffee	How much per day? _____	How long? _____
Tea	How much per day? _____	How long? _____
Soft Drinks	How much per day? _____	How long? _____

Do you exercise? Yes or No

If yes, what kind of exercise and how much? _____

Patient's Name:_____ DOB_____

REVIEW OF SYSTEMS:

Have you ever had temporary blindness or double vision?		Yes	No
Do you suffer from nosebleeds?		Yes	No
Do you suffer from shortness of breath?		Yes	No
Do you suffer from chronic coughing or wheezing?		Yes	No
Have you ever coughed up blood?		Yes	No
Have you ever experienced chest pain or chest tightness?	Date:_____	Yes	No
Do you have palpitations (skipping or racing heartbeat)?		Yes	No
How many pillows do you use to sleep on and why? _____ for comfort_____ for breathing_____			
Have you ever passed black, tarry bowel movements?		Yes	No
Have you ever had blood in your urine or stool?		Yes	No
Have you ever passed out?		Yes	No
Do your feet and ankles swell?		Yes	No
Do you have problems with constipation?		Yes	No
Do you have problems with diarrhea?		Yes	No
Do you have difficulty swallowing?		Yes	No
Do you have difficulty urinating?		Yes	No
Do you have pain or burning upon urination?		Yes	No
Have you recently experienced unusual anxiety or stress?		Yes	No
Have you ever had vertigo (severe dizziness)?		Yes	No
Do you suffer from migraines or frequent headaches		Yes	No
Have you ever had seizures or tremors?		Yes	No
Do you have leg pain when you walk?		Yes	No
Do you have any form of arthritis?		Yes	No
Do you have any ulcers on your feet?		Yes	No
Have you had recent unexplained weight loss or weight gain?		Yes	No
Have you had recent fever or shaking chills?		Yes	No

Patient signature: _____ Date:_____

Physician Signature: _____ Date:_____