Southern Heart Group, P.A.

# NEW PATIENT EVALUATION

NAME: ______________________________ DATE: ____/____/____

Date of Birth ______________ Age ______________ Referring Physician ______________________

## DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (please indicate by circling answers)

1. CHEST PAIN Yes No (if no, please proceed to number 2)

   TYPE: Heaviness Tightness Pressure Squeezing Sharp Dull

   DURATION: Seconds Minutes Hours Days

   OCCURS: At Rest With Activities Heavy Activities Light Activities

   FREQUENCY: Constant Every Day Every Few Days Every Few Weeks

   Frequency Increased Recently Stable Symptoms Recently

2. SHORTNESS OF BREATH: Yes No (if no, please proceed to #3)

   At Rest With Extreme Activity With Light Activity

3. PALPITATIONS: Yes No
4. DIZZINESS Yes No
5. SWELLING IN LOWER EXTREMITIES: Yes No

## RISK FACTORS FOR CORONARY DISEASE (please check the appropriate response):

1. Are you being given medications for high blood pressure? Yes ( ) No ( )

   How long have you been taking medications? ____________ years

2. Are you being treated for diabetes? Yes ( ) No ( )
3. Have you ever been told that you have a high cholesterol level? Yes ( ) No ( )
4. Do you smoke cigarettes? Yes ( ) No ( )

   If yes, how much? ______ packs per day. How long have you smoked? ________ years.

   If no, did you ever smoke? Yes ( ) No ( ) When did you stop? ________ years ago.

5. Do you exercise on a regular basis? Yes ( ) No ( ) If yes, how often? ________ days per week.

   For how long (each exercise period)? ________ minutes.

6. Do you experience leg pain while walking? Yes ( ) No ( )

**PAST MEDICAL HISTORY:** Please list any chronic medical condition or prior surgical procedures and the year if occurred:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

**HOSPITILIZATIONS:** Please list any other hospitalizations: year and reason

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

**MEDICATIONS:** Please list any medications you take on a daily basis (including vitamins, herbal supplements, over the counter medications and Viagra). Please include name, dose, and frequency taken.

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________
7. ______________________ 8. ______________________
9. ______________________ 10. ______________________

## SOCIAL HISTORY:

1. What is (was) your job? ______________________ Retired? Yes ( ) No ( )
2. What company do you work for? ______________________
3. Are you (please check one): Married ( ) Single ( ) Divorced ( ) Widowed ( )
4. Do you have children? Yes ( ) No ( ) If yes, how many? ________male ________ female
5. Do you drink caffeinated coffee? Yes ( ) No ( ) If yes, how much? __________ cups per day.
6. Do you drink alcohol? Yes ( ) No ( ) If yes, how much? __________ drinks per week.

**ALLERGIES:** Please list any allergies to medications, food (including seafood), or adhesive tape

______________________________________________________________________

**FAMILY HISTORY**: If anyone in your blood related family has the disease below, please check the appropriate box.

| Description | Mother | Father | Sister | Brother | Grandmother | Grandfather | Aunt | Uncle |
|---|---|---|---|---|---|---|---|---|
| Diabetes | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Heart Attack (list age 1st occurred) | | | | | | | | |
| Bypass Surgery | | | | | | | | |
| Angioplasty or Stent | | | | | | | | |
| Heart Valve Disease | | | | | | | | |
| Stroke | | | | | | | | |
| Kidney Disease | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Cancer (list type) | | | | | | | | |

**SYSTEMS REVIEW**: Have you ever had the following symptoms/diseases in the past?

| Description | Yes | No | Description | Yes | No |
|---|---|---|---|---|---|
| Thyroid Disease | | | Kidney Stones | | |
| Gout | | | Seizures | | |
| Hepatitis | | | Migraine Headaches | | |
| Jaundice | | | Gallstones | | |
| Asthma | | | Broken Bone | | |
| Ulcers | | | Depression | | |

**Do you have the following symptoms on a FREQUENT basis?**

| **Description** | **Yes** | **No** | **Description** | **Yes** | **No** | **Description** | **Yes** | **No** |
|---|---|---|---|---|---|---|---|---|
| Fevers | | | Cough | | | Burning Urine | | |
| Large Weight Change | | | Sputum in morning | | | Blood in urine | | |
| Night Sweats | | | Blood in Sputum | | | Back Pain | | |
| Skin Rash | | | Nausea | | | Muscle Weakness | | |
| Nose Bleeds | | | Vomiting | | | Joint pain | | |
| Hearing Loss | | | Constipation | | | Joint Swelling | | |
| Sinus Infection | | | Diarrhea | | | FOR WOMEN: | | |
| Earache | | | Black Stool | | | Hot flashes | | |
| Ringing in Ears | | | Rectal Bleeding | | | Irregular periods | | |

# PATIENT INFORMATION

## PLEASE PRINT CLEARLY

PATIENT NAME ______________________________________________________________ MI __________ SEX __________

ADDRESS ______________________________________________________________ STATE _________ ZIP ______________

PHONE # ______________________________ DATE OF BIRTH ______________________ AGE __________ SS# ___________________

RACE ___________________________ DRIVER'S LICENSE # ___________________________

EMPLOYED? Y N If yes, please list employer ________________________________________________________________________

MARITAL STATUS _______ MARRIED _______ SINGLE ___________DIVORCED ___________ WIDOWED

SPOUSE'S NAME ____________________________________________________________ DATE OF BIRTH ______________________

PRIMARY PHYSICIAN _______________________________________________________________________________

EMERGENCY CONTACT (Please list a person who does **NOT** live with you) : _____________________________________________________

Relation to patient: _____________________________________ Phone #1: ________________________ Phone #2: ____________________

## PRIMARY INSURANCE

INSURED PARTY'S NAME ___________________________________________________________ DOB ________________ AGE ______

SEX ______ ADDRESS ___________________________________________________ CITY _____________ STATE_____ ZIP ________

PHONE # ______________________________ SS# __________________________ DRIVER'S LICENSE # _________________________

EMPLOYER'S NAME ______________________________________________________________________________

ADDRESS ____________________________________________________________ CITY __________ STATE ______ ZIP _____________

INSURANCE PLAN/PROGRAM NAME ____________________________________________________ PHONE # ____________________

INSURANCE ID # ___________________________________________ POLICY OR GROUP # ____________________________________

INSURANCE ADDRESS ____________________________________________ CITY __________________ STATE _____ ZIP__________

## SECONDARY INSURANCE

__________ No Secondary Insurance

INSURED PARTY'S NAME ______________________________________________________________ DOB _______________ AGE ____

SEX _______ ADDRESS ____________________________________________________ CITY ___________ STATE______ ZIP _________

PHONE # ________________________________ SS# ____________________________ DRIVER'S LICENSE # _____________________

EMPLOYER'S NAME ______________________________________________________________________________

ADDRESS _______________________________________________________________ CITY __________ STATE ______ ZIP ___________

INSURANCE PLAN/PROGRAM NAME _________________________________________________ PHONE # _______________________

INSURANCE ID # ______________________________________________ POLICY OR GROUP # _________________________________

INSURANCE ADDRESS ___________________________________________ CITY __________________ STATE _____ ZIP__________

# LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

Southern Heart Group P.A., Division C works with it's patients to minimize difficulty in the payment of fees for service. You will be asked to pay those minimal unmet deductible amounts and co-insurance amounts which your insurance company authorizes us to collect. We automatically file insurance claims with your insurance company. Therefore, please insure that primary and secondary insurance information is correct.

**Authorization to Release Information.** I authorize Southern Heart Group, P.A., Division C to release any and all information pertaining to my diagnosis and treatment to any insurance company or companies and to any physician or healthcare provider to whom I may be referred.

**Assignment of Benefits.** I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to Southern Heart Group, Division C.

**I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE**

This assignment will remain in effect until revoked by me in writing .

DATE: ________________________________ PATIENT: __________________________________________________

**AUTHORIZATION TO RELEASE MEDICAL RECORDS TO INDIVIDUALS OTHER THAN MYSELF**

______________________________________________________________________________

Individual's Name

______________________________________________ ___________________________

Patient Signature Date

**AUTHORIZATION TO PROVIDE VERBAL INFORMATION TO INDIVIDUALS OTHER THAN MYSELF**

______________________________________________________________________________

Individual's Name

______________________________________________ ___________________________

Patient Signature Date