Associates in Cardiovascular Disease

PATIENT NAME:_____ DATE OF BIRTH:_____ AICD PHYSICIAN:_____

TODAYS DATE:_____ DATE OF YOUR NEXT VISIT:_____

PRIMARY CARE PHYSICIAN:_____ PATIENT E MAIL:_____ PHONE:_____ CELL #:_____

EMERGENCY CONTACT NAME AND PHONE:_____

PHARMACY NAME/TOWN:_____ MAIL AWAY PHARMACY:_____

REASON FOR YOUR VISIT :_____ WHO REFERRED YOU TO US? □ Primary Care Physician □ Specialist/OB-GYN Physician ☐ Internet Search ☐ Ad ☐ Other:

RISKS:

Tobacco

_____Y____N_____Former

____Packs/day

_____Year quit

High Cholesterol

____Y_____N_____Unknown

Diabetes

__Y__N

_____Year Diagnosed

High Blood Pressure

____Y_____N_____Unknown

_____Year Diagnosed

Family History of Heart Disease

____Y_____N_____Unknown

Alcohol

__Y__N__Former

____Year quit

__Daily__Rarely__Socially

Caffeine

__None__Coffee__Tea__Soda

SOCIAL HISTORY

Marital status:

__M__D__S__W

Children__Y__N__#

Race:*

____ Hispanic/Latino

____Not Hispanic or Latino

Ethnicity:*

____White

____Black

____Hispanic

____Asian/Pacific Islander

____American Indian/Alaska native

____Other/Unknown

*Above information required by the Government

Lifestyle

Diet:

__Regular

__Low fat, low cholesterol

__Low salt

__Diabetic

Exercise

__Sedentary

__Occasional

__Regular

__Active Lifestyle

__Physically unable

YOUR FAMILY HISTORY **(Include only the following: Heart disease, diabetes, stroke, cancer)**

(Include parents, siblings)

	Family Member	Age of Onset/or age of Death	Pertinent History
1.			
2.			
3.			
4.			
5.			
6.			
7			
8.			
9.			
10			

YOUR MEDICAL HISTORY: **List any illnesses you have or are being treated for :**

Include ALL HOSPITALIZATIONS and SURGERIES in the past five years

	Include Reason for admission and/or type of surgery	Year
1.		____
2.		____
3.		____
4.		____
5.		____
6.		____
7.		____
8.		____
9.		____

ASSOCIATES IN CARDIOVASCULAR DISEASE

PATIENT NAME: _____ DATE OF BIRTH:_____ **PAGE 2**

Have you ever had any of the following tests?

	Location	Year
___Stress test	_____	____
___Echocardiogram	_____	____
___Cardiac catheterization	_____	____
___Carotid ultra sound	_____	____
___Cardiac Bypass	_____	____
___Cardiac Stent/Angioplasty	_____	____
___Implantable Defibrillator	_____	____
___Pacemaker	_____	____

Have you ever had any of the following?

	Year
__Heart attack	____
__Shortness of breath	____
__Heart murmur	____
__Rheumatic fever	____
__Abnormal heart rhythm	____
__Palpitations	____
__Leg cramps while walking	____
__Stroke	____
__TIA (Mini stroke)	____
__Enlarged heart	____
__Chest pain/pressure	____
__Dizziness	____
__Swollen legs	____
__Heart failure	____
__Fainting/nearly fainting	____

Have you ever had any of the following?

	Year
___ Diabetic retinopathy	____
___ Macular degeneration	____
___Asthma	____
___COPD	____
___Pulmonary embolism	____
___Sleep Apnea	____
___Gallbladder Disease	____
___GERD (reflux)	____
___Peptic Ulcer	____
___GI Bleed	____
___Hysterectomy	____
___Psoriasis	____
___Diabetic neuropathy	____
___Migraines	____
___Hyperthyroid	____
___Hypothyroid	____
___Cancer ; Type_____	____
___Anemia	____
___Easy brusing/bleeding	____
___Bipolar disorder	____
___Anxiety	____
___Depression	____

ALLERGIES

_____
_____
_____
_____
_____

MEDICATIONS (Include over the counter)

Medication	Dose	Frequency
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Primary Language:_____

****Above information required by government**

ASSOCIATES IN CARDIOVASCULAR DISEASE

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Associates in Cardiovascular Disease's Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Associates in Cardiovascular Disease, LLC for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

_____	_____
Print Patient's Name	**Date of Birth**
_____	_____
Signature of Patient/Parent/Guardian	**Date**

☐ **Check here if you do not wish voice messages to be left on your answering machine or voicemail.**

Daytime phone number:_____

II. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Associates in Cardiovascular Disease (AICD) may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by AICD for the purpose of making the disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request to AICD.

Print Name:_____ Relationship:_____Date of Birth:_____

Print Name:_____ Relationship:_____Date of Birth:_____

Print Name:_____ Relationship:_____Date of Birth:_____

_____	_____
Signature of Patient/Parent/Guardian	**Date**