Delaware Cardiovascular Associates

Patient Health History

NAME: ______ DATE OF BIRTH: / /

Address: ______
City: ______ State: ______ Zip: ______ Sex: Male / Female
Phone Number: (Home): ______ (Cell): ______ (Work): ______
Social Security #: ______ Race: ______ Ethnicity: ______
Primary Care Physician: ______ Referring Physician: ______
Occupation: ______ Are You Retired? Yes / No
Do You Have a Living Will? Yes / No Does your insurance require a referral? Yes / No
Email: ______ Visit Reason: ______
Would you like to participate in an interactive Patient Portal to view your medical history online? Yes/ NO

ALLERGIES: ☐ No Known Allergies ☐ YES If so, please list all Drug, Food, and Environmental Allergies.

______

MEDICATIONS: ☐ No Current Medications

Please list all current medications that you are taking and their corresponding dosages below (if known):

Medication	Dosage	Medication	Dosage

PREFERRED PHARMACY:

Name of Pharmacy: ______
Pharmacy Location (*Street, City, State*): ______
Pharmacy Phone Number (if known): ______

REVIEW OF SYSTEMS ☐ No Current Problems; or please check all that apply

☐ Numbness in Hands/Feet	☐ Difficulty Swallowing	☐ Cough	☐ Nose Bleeds
☐ Difficulty Hearing	☐ Swelling in Feet/Ankles	☐ Coughing up Blood	☐ Vomiting
☐ Double Vision	☐ Excessive Thirst	☐ Night Sweats	☐ Diarrhea
☐ Abdominal Pain	☐ Swelling of Legs	☐ Skin Rash	☐ Constipation
☐ Leg Pain when walking	☐ Frequent Urination	☐ Trouble Sleeping	☐ Mood Swings
☐ Bloody Bowels	☐ Black Bowels	☐ Weight Loss	☐ Fever
☐ Painful Urination	☐ Chills	☐	☐

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PERSONAL MEDICAL HISTORY:

☐ No Known Problems; or please check all that apply

☐ Anemia	☐ COPD	☐ High Blood Pressure	☐ Peripheral Artery Disease
☐ Anxiety/Depression	☐ Diabetes	☐ HIV/AIDS	☐ Renal Disease
☐ Arrhythmia	☐ Diverticulitis	☐ Hyperthyroidism	☐ Seasonal Allergies
☐ Arthritis	☐ Headaches/Migraines	☐ Hypothyroidism	☐ Seizures/Epilepsy
☐ Asthma	☐ Heart Attack	☐ Hyperlipidemia	☐ Sexual Dysfunction
☐ Blood Clots/DVT	☐ Heart Murmur	☐ Leg Pain	☐ STD
☐ CHF	☐ Heart Palpitations	☐ Mental Illness	☐ Stroke/TIA
☐ Chronic Pain	☐ Heart Stent	☐ Numbness in Extremities	☐ Swelling of Extremities
☐ Claudication	☐ Heart Surgery	☐ Pacemaker	☐ Other:

PROCEDURES & SURGERIES:

☐ None ☐ YES. If so, please list all Procedures/Surgeries with dates below.

Procedure	Date(s)	Procedure	Date(s)

FAMILY HISTORY: (check all that apply)

☐ Negative ☐ Unknown ☐ Unable to Obtain ☐ Adopted

Type	*Mother*	*Father*	*Sister*	*Brother*	*Grandmother Maternal*	*Grandmother Paternal*	*Grandfather Maternal*	*Grandfather Paternal*
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐	☐	☐

Name: **Date of Birth:** / /

SOCIAL HISTORY:

Alcohol:	☐ Current	☐ Past	☐ Never
Please check if applicable:	☐ Beer	☐ Wine	☐ Liquor
Tobacco Use:	☐ Current	☐ Past	☐ Never
Please check if applicable:	☐ Cigarettes	☐ Cigar	☐ Oral
	☐ Pipe	☐ Snuff	☐ Other
Drug Use:	☐ Current	☐ Past	☐ Never
Please list if any:			
Exercise & Physical Activity:	☐ Never	☐ 1-2 times/wk	☐ 3-4 times/wk
	☐ 5-6 times/wk	☐ Daily	☐ Other:

Name: Date of Birth: / /

Patient Communication Permission

Permission to Leaving Messages <u>On Answering Machine</u>
Appointments Only: YES / NO Medical Care & Medication Refills: YES / NO

Office Staff Permission <u>to Speak to Family Member</u>
Appointments Only: YES / NO Medical Care & Medication Refills: YES / NO

If yes, please list name(s) and relationship(s) of whom we may speak with regarding the above.

Authorization for the Release of Medical Information/Assignment of Benefits

Patients are responsible for services rendered. Necessary forms (including referrals) will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. <u>It is also required that payment for co-payments is rendered at the time of service.</u> I understand that if improper insurance information or referrals are not obtained for any visit(s), I may be billed for the amount(s).I request that payment of authorized Medicare and/or Other Insurance Company benefits be made directly to Delaware Cardiovascular Associates on my behalf for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I understand that any or all of my medical information may be used for blinded-data research, in which none of the data will be linked to my indemnity. I understand that my medical information may be electronically submitted to any or all of my treating physicians, hospital and/or healthcare entities. I permit a copy of this authorization to be used in place of original, and request payment of medical insurance benefits to the party who accepts assignment. I authorize to retrieve medical information from outside sources including hospitals, pharmacies, laboratories and imaging centers.

Notices of Privacy Policies

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (2) obtain payment from third party payers; and/or (3) conduct normal healthcare operations such as the quality assessments and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I also understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

"I HAVE READ THE AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION/ ASSIGNMENT OF BENEFITS WITH NOTICES OF PRIVACY POLICIES AND I ACCEPT."	
SIGNATURE:	Today's Date: / /