SAINT FRANCIS HEART AND VASCULAR CENTER
NEW PATIENT QUESTIONNAIRE

Please Print

Name		Date
Age	Date of Birth	Gender M F T
Marital Status	Occupation	
Primary Care Physician		
Reason For Today's Visit		
Home Pharmacy		

Chronic Health Problems (mark with a √ all that apply)

High Blood Pressure		Diabetes		High Cholesterol		Heart Attack		Angina	
Stroke		COPD		Asthma		Kidney Disease		Cancer	

Other

Immunization Dates: Tetanus_____ Pneumonia_____ Flu_____

Surgical History (list name and date)

Surgery	Date

List prescription medication & over-the-counter supplements you take, the dose and how you take it.

Medication Name	Dose/Time	Reason

Use reverse if needed.

NAME:_____

ALLERGIES:

List all known allergies (i.e. food, medication, tape, latex, or soaps) and describe the reaction.

SOCIAL HISTORY

Marital Status: Single_____ Married_____ Widowed_____

Work History: Occupation: _____Still working ____ Retired _____

Tobacco use: Have you ever smoked? Yes _____ No _____ Quit When _____
How much? _____ Age started _____
Do you chew tobacco or snuff tobacco? Yes___ No___ Quit When_____

Alcohol Use: Yes __ No __ Occasionally ___ How much _____How Often_____
Are you an alcoholic? Never__ Rare___ Social____ Are you a recovering alcoholic? Yes___ No_____

Recreational Drug Use: Yes___ No___
Vision/Hearing Impairment: Yes___ No___
Describe_____
Do you have any trouble following or understanding directions? Describe_____

COMPLIMENTARY THERAPIES

Do you use any other complimentary therapies? (Biofeedback, meditation, visualization, vitamin therapy, herbal therapy, massage therapy, etc.) Yes___ No___ List_____

FAMILY HISTORY

(Father, Mother, Siblings, Grandparents)

History of:	Yes	No	**History of:**	Yes	No
Diabetes			Kidney Disease		
Heart Disease			Depression		
Sickle Cell Disease			Other Psychiatric Illness		
High Blood Pressure			Arthritis/Gout		
Bleeding Disorder			Dementia/Alzheimer's		
Lung Disease			Cancer:		
Stroke or CVA			Who and what type?		

Other family medical problems:_____

_____

_____

NAME_____

REVIEW OF SYSTEMS – Indicate all personal history below with a √ for all yes answers.

SYMPTOMS		HEART		INTEGUMENTARY (SKIN)	
	Fever		Chest pain/tightness		Rashes
	Night Sweats		History of heart attack		Masses
	Weight Change		Known heart murmur		Dry Skin/Hair
EYES			Racing heart rate		Sores that won't heal
	Double Vision		Irregular Beats		Changes in warts or moles
	Glaucoma/Cataracts		Pacemaker	**NEUROLOGICAL**	
	Glasses/Contacts		Swelling of ankles/feet		Intense headaches
	Blurring		**GASTROINTESTINAL**		Black outs
EAR, NOSE, THROAT			Loss of appetite		Convulsions/seizures
	Deafness/Hearing aides		Nausea/Vomiting		Numbness or Tingling
	Sinus Problems		Vomit blood		Tremors
	Nose Bleeds		Bleeding hemorrhoids		Paralysis
	Dental/Teeth problems		Black, tarry stools	**PSYCHRIATRIC**	
	Wear dentures		Heartburn/indigestion		Depression
RESPIRATORY			Difficulty swallowing		Hallucinations
	Shortness of Breath resting		Constipation		Mood Swings
	Shortness of breath activity		Diarrhea		Psychiatric treatment
	Chronic Cough		Abdominal pain	**ENDOCRINE**	
	Cough up phlegm/sputum		**GENITOURINARY**		Hair loss
	Cough up blood		Decreased urine flow		Heat/Cold intolerance
	History of asthma		Flank pain		Hoarseness
	Wheezing		Hard to start stream		History of thyroid problems
	Sleep Apnea/snoring		Painful/Frequent urination		Excessive thirst/urination
	Use CPAP at home		Blood in urine		Hepatitis exposure
	Use oxygen at home		Sexually transmitted disease	**HEMATOLOGY**	
	Known TB exposure		Decreased sex drive		Bleeding tendency
	MUSCULOSKELETAL		**MALES**		Bruising tendency
	Joint Pain		Difficulty with erections		Anemia
	Joint stiffness/swelling		**FEMALES**		Blood clots
	Weakness of muscles		Date of last period		Blood transfusion
	Muscle pain or cramps		Last pelvic/Pap		Lymph node enlargement
	Chronic back pain		Last mammogram		Tender neck
	Difficulty walking		Menstrual problems		
	Tingling in hands		Might you be pregnant		

Name (please print)

Date of Birth

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Through the Health Insurance Portability and Accountability Act (HIPPA), the Department of Health and Human Services established national standards for the privacy of protected health information (PHI). In compliance with these Federal regulations, St. Francis Heart and Vascular Center may not discuss your medical care with anyone without your expressed written permission, except in the case of an emergency or as required by law. This does not apply to disclosing information to carry out treatment, payment or health care operations.

Please list below the full names of people with whom you give St. Francis Heart and Vascular Center authorization to discuss your case (i.e., medication refills, test results, appointment scheduling, billing information, medical history, etc.). Examples include spouse, parent(s), child, sibling, significant other, friend, interpreter, etc.

If you choose not to name anyone, please indicate "NO ONE."

PLEASE NOTE: This does apply to minor children (18 years of age or younger). We do need your permission to discuss your care with anyone – including your parent(s).

1. _____
2. _____
3. _____
4. _____

Signature

Date