Treasure Coast
HEART VASCULAR
COMPLETE CARDIOVASCULAR CARE

PLEASE PRINT

Circle one:

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (last): _____ (First): _____ (MI): __

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ **Email**: _____

How did you hear about us? _____

Primary Care Provider (PCP): _____ Phone: _____

Referring Provider: _____ Phone: _____

Race: _____ Ethnicity: _____ Language: _____

Marital Status: _____ Social Security Number: _____-_____-_____

Emergency Contact (Last): _____ (First): _____

Phone Number: _____ Do you have a living will? _____

Emergency Contact relationship to Patient: _____

Responsible Party information: Self or Other: _____

Primary insurance: (PLEASE PROVIDE YOUR INSURANCE CARD TO FRONT DESK AT CHECK IN)

Insurance Company: _____ Phone: _____

Named Insured: _____ Patient relationship to insured: _____

Subscriber ID (Policy Number): _____ Group: _____

Secondary Insurance:

Insurance Company: _____ Phone: _____

Named Insured: _____ Patient relationship to insured: _____

Subscriber ID (Policy Number): _____ Group: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or responsible Party) signature: _____ Date: _____

PATIENT HISTORY FORM

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Chief Complaint: What is the main reason for your visit today? _____

_____

PAST MEDICAL HISTORY

Stomach Disease	**□No**	**□Yes**
Ulcer	**□No**	**□Yes**
Diverticulitis	**□No**	**□Yes**
High Blood Pressure	**□No**	**□Yes**
Heart Attack	**□No**	**□Yes**
High Cholesterol	**□No**	**□Yes**
Stroke	**□No**	**□Yes**
Diabetes (Sugar)	**□No**	**□Yes**
Asthma	**□No**	**□Yes**
Bronchitis	**□No**	**□Yes**
Emphysema	**□No**	**□Yes**
Black Lung	**□No**	**□Yes**
Liver Disease	**□No**	**□Yes**
Blood clotting problems	**□No**	**□Yes**
Kidney Disease	**□No**	**□Yes**
Kidney Stone	**□No**	**□Yes**
Venereal Disease	**□No**	**□Yes**
Aids/HIV	**□No**	**□Yes**
Convulsions	**□No**	**□Yes**
Arthritis/Gout	**□No**	**□Yes**
Back Trouble	**□No**	**□Yes**
Cancer	**□No**	**□Yes**

Previous Hospitalizations/Surgeries/Serious Illness When?

_____

_____

_____

Other Medical History _____

_____

Do you take any medication? If yes, see page 6.

Do you take any of the following?

Aspirin □Yes □No How much/how often? _____

Coumadin (warfarin) □Yes □No How much/how often? _____

Plavix (clopidogrel) □Yes □No How much/how often? _____

Lovenox (enoxaparin) □Yes □No How much/how often? _____

Do you take anything else that makes your blood thinner? _____

Are you allergic to any medications? □Yes □No If yes, which ones?

_____

Do you have any seasonal allergies? □Yes □No

(i.e. pollens, grass, tress, cat/dog, etc.)

SOCIAL HISTORY:

Marital Status: □Single □Married □ Separated □Divorced □Widowed

Use of Alcohol: □Never □Rarely □Moderate □Daily

Use of Tobacco:

Cigarettes □No □Yes If yes, how much do you use in a day's time? _____

Smokeless Tobacco □No □Yes If yes, what type do you use and how much in a day's time? _____

Use of Illicit Drugs:

Current □No □Yes If yes, what type and how often? _____

Past □No □Yes If yes, what type and how often? _____

FAMILY MEDICAL HISTORY

Diabetes	**□Yes**	**□No**	**Lung Cancer**	**□Yes**	**□No**
Tuberculosis	**□Yes**	**□No**	**Kidney Disease**	**□Yes**	**□No**
Heart Disease	**□Yes**	**□No**	**Heart Attack**	**□Yes**	**□No**
Liver Disease	**□Yes**	**□No**	**Colon Cancer**	**□Yes**	**□No**
Prostate Cancer	**□Yes**	**□No**	**Stroke**	**□Yes**	**□No**
Bladder Cancer	**□Yes**	**□No**	**High Blood Pressure**	**□Yes**	**□No**
Breast Cancer	**□Yes**	**□No**	**Kidney Cancer**	**□Yes**	**□No**

Other_____

Chief Complaint:

	Right	Left	BOTH	Where?	How Often?
Edema/Swelling					
Varicose Veins					
Spider vein					
Tiredness/Fatigue					
Burning					
Itching					
Cramping					
Restless Legs					
Ulcers					
Rash/irritation					
Pigmentation					
Bulging Veins					
Bleeding					
Pain/Aches					
Heaviness/Fullness					
Stiffness					
Throbbing					
Severity Pain 1-10					

❑ Additional Complaints

	Right	Left	Both	
Intermittent Claudication				
Numbness				
Coldness of feet				
Other				

Chief Complaint:

Number of Pregnancies:

(Full-term and Incomplete): 0 1 2 3 4 5 6

Quality of pain:

- ❑ Sharp
- ❑ Dull
- ❑ Pulling
- ❑ Throbbing
- ❑ Tightness
- ❑ Heavy
- ❑ Discomfort

History of Present Illness:

Date symptoms started: _____

Symptoms worsening since: _____

Have you worn 20/30 compression stockings?

❑ Yes ❑ No

Compression Stocking Prescribed By: _____

Regular use of Compression since: _____

Have symptoms Improved? ❑ Yes ❑ No

Previous history is significant for following complication of venous disease:

	Right	Left	Both	Recurrent
Venous Insufficiency				
Bleeding				
DVT				
PE				
Ulcer				
SVT/Phlebitis				

Aggravating Factors:

- ❑ Prolonged sitting
- ❑ Prolonged standing
- ❑ Walking/Exercise
- ❑ Hot weather
- ❑Menstrual
- ❑ Pregnancy
- ❑ Other:

Relieving Factors:

- ❑ Elevation
- ❑ Walking/Exercise
- ❑ Wrapping/Compression Stocking
- ❑ Medication
- ❑ Hot Bath/Showers
- ❑ Warm soaks/heating pad
- ❑ Cold packs
- ❑ Sitting down/resting
- ❑ Massage

Do your leg issues stop you from doing your daily activities? If yes, please explain (AS REQUIRED BY YOUR INSURANCE COMPANY)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Do you now have or have had any problems related to the following systems? Check BOX. If any other condition please write on the line.

General/Constitutional:

- ❑ Wheelchair-Bound
- ❑ Overweight
- ❑ Dizziness
- ❑ Change in Appetite
- ❑ Chills
- ❑ Fever
- ❑ Headaches
- ❑ Weight Gain
- ❑ Weight Loss

Ent:

- ❑ Decreased Hearing
- ❑ Decreased Sense of Smell
- ❑ Difficulty in Swallowing
- ❑ Ear Pain
- ❑ Month Breathing at Night
- ❑ Nosebleed
- ❑ Ringing in The Ears
- ❑ Snoring

Endocrine:

- ❑ Cold Intolerance
- ❑ Diabetes
- ❑ Weakness
- ❑ Thyroid Problems
- ❑ Frequent Urination

Respiratory:

- ❑ Asthma
- ❑ Chest Pain
- ❑ Cough
- ❑ Short of Breath
- ❑ Pneumonia
- ❑ COPD
- ❑ Sleep Apnea

Cardiovascular:

- ❑ GERD
- ❑ Liver Disease
- ❑ Stent
- ❑ Abdominal Pain
- ❑ Lung Disease

Genitourinary:

- ❑ Urinary Incontinence
- ❑ Dialysis
- ❑ Kidney Problems

Musculoskeletal:

- ❑ Muscle Pain/Aches
- ❑ Generalized Aches
- ❑ Generalized Weakness
- ❑ Pain/Cramping
- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Pain in Joints

Peripheral Vascular:

- ❑ PAD
- ❑ PVD
- ❑ Varicose Veins
- ❑ Foot Pain at Night
- ❑ Ulcer
- ❑ Leg Cramps
- ❑ Blood Clots
- ❑ Coolness in Extremities

Skin:

- ❑ Rash
- ❑ Eczema
- ❑ Discoloration
- ❑ Skin Cancer

Neurologic:

- ❑ Dizzy Spells
- ❑ Numbness
- ❑ Tingling
- ❑ Tremors
- ❑ Memory Loss
- ❑ Stroke
- ❑ Syncope
- ❑ Poor Balance
- ❑ Confusion

OTHER CONDITIONS OR DISEASES:

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS	DOSE	ROUTE	FREQUENCY (PER DAY)

PREFERRED PHARMACY NAME: _____

LOCATION: _____

Treasure Coast
HEART VASCULAR
COMPLETE CARDIOVASCULAR CARE

CARDIOLOGY/VASCULAR

AUTHORIZATION FOR MEDICAL RECORDS INFORMATION

Full Name _____

Date of Birth_____ SS# _____

I hereby authorize**: Treasure Coast Heart and Vascular at 1801 SE Hillmoor Dr. Suite C208, Port Saint Lucie, Florida 34952 Phone: 772-337-5083, Fax 772-337-5088**

To obtain my records and medical information from:

Name: _____
Address: _____
Phone/fax: _____

__ Complete Medical Records ___History & Physical ___ Office Notes ___ Lab/X-ray reports

__Discharge Summary ___ Emergency Records ___Others _____

My records may contain the following information unless crossed out; I specifically authorize them to be released:

HIV Test results Psychiatric Mental or Emotional records AIDS related records Drug or Alcohol records

The Information is to be used for the purpose of continuity of care unless otherwise noted _____
Pursuant to Florida law, the record may be used only for the purpose provided and to whom requested. Any information may not be re-disclosed to any other person without the specific written consent of the undersigned. Charges follow Florida law. I understand I may revoke this consent at any time, I must do so in writing and present to Healthy Heart Center Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization. This consent expires in twelve (12) months unless another date is written here:

I understand that authorization of disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

Healthy Heart Center Inc. is hereby released from any responsibility for maintaining confidentiality of information released to me or parties designated by me in this authorization, such release being made in good faith.

PATIENT SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT _____
(Explain and/or attach legal documentation)

WITNESS SIGNATURE _____ DATE _____

PATIENT HIPPA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Name: _____ Date: _____

Notice of Privacy Practices. I acknowledge that I have received the Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I Have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the Providers business associates, to the extent permitted by law, I consent to the use and disclosure of my information for the purpose described in the practice's Notice of Privacy Practices.

Release of Information. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

Healthcare information regarding prior admission(s) at any facilities may be available to subsequent admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patients behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Health information may also be released to my employer's designee when services delivered are relate to a claim under worker's compensation.

If I am covered by Medicare or Medicaid, I authorize the release of Information to Social Security Administration or its intermediaries or carrier for payment of a Medicare claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers and/or other health care industry participants and their subcontractors for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information: aggregating and comparing my information for the quality improvement purposes: and such other purposes as may be permitted by laws. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disabilities, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to blood borne diseases, such as HIV and AIDS.

Disclosure to Friends and/or Family Members:
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER CAN DISCUSS YOUR MEDICAL CONDITION? IF YES PLEASE LIST PERSON(S) BELOW:

Name	Relationship	Phone

1. _____

2. _____

Patient Signature: _____ Date: _____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (l) you intend that this consent is continuing in nature even after a specify diagnosis has been made and treatment recommended: and (2) you consent to treatment at this office or any other satellite office under common Ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider. we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant. or Clinical Nurse Specialist). and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination. testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or intentional procedures are recommended. I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal representative: _____ Date: _____

Printed Name of Patient or Personal representative: _____

Relationship to Patient: _____

Printed Name of Witness: _____ Job title: _____

Signature of Witness: _____ Date: _____

Treasure Coast
HEART VASCULAR
COMPLETE CARDIOVASCULAR CARE

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, and kidneys, become narrowed or clogged. It affects over 12 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficulty controlling blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Last Name_____ **First Name**_____ **Date of Birth**____

Primary physician _____

Please CIRCLE 'Yes' or 'No'and indicate which leg	**Yes or No**	**Which Leg?**
1. Do you experience discomfort, fatigue, aching, tingling, cramping, or pain in your feet, calves, thighs, or buttocks when you walk or exercise?	Yes No	Left Right Both
2. If you answered yes to #1, does the pain go away with rest?	Yes No	Left Right Both
3. Do you experience any pain at rest in your lower leg(s) or feet?	Yes No	Left Right Both
4. Do you ever require assistance to walk *(i.e., cane, walker, motorized cart, someone's arm)?* If so, please explain: _____	Yes No	Left Right Both
5. Have you been diagnosed with diminished or absent pedal (foot) pulses?	Yes No	Left Right Both
6. Have you ever been diagnosed with arthritis, nerve damage, disk herniation, or a disease related to your bones and/or spine?	Yes No	Left Right Both
7. Have you had any procedure to treat any blood vessels?	Yes No	Left Right Both

8. Are you experiencing any of the following on your legs, feet, toes, below the knee? *Please check all that apply.*

_____ Pale, discolored, or bluish
_____ Dry or atrophic or shiny skin
_____ Ulcers, sores, slow healing wounds (8-12 weeks)
_____ Hair loss or uneven distribution over time
_____ Dystrophy brittle nails
_____ Infection that may be gangrenous (black skin)

9. Risk Factors (*please check all that applies and specify when indicated.*)

_____ Smoking History/Date quit____/___/___
_____ Diabetes
_____ Coronary Artery Disease
_____ Chronic Kidney Disease, stage:_____
_____ Congestive Heart Failure
_____ High Cholesterol
_____ Previous Stroke/ TIA
_____ Hypertension
_____ Previous Obstructive Vascular Disease
_____ Age >50

Patient Signature_____ Date_____

Additional Notes: _____