Tri-County HEART INSTITUTE

PATIENT INFORMATION FORM

Patient Demographics

Last Name:	First Name:		MI:	Date of Visit:
Date of Birth:	Age:	Sex:	Height:	Weight:
Home Phone:	Cell:		Email:	
Do you want to be Web Enabled? ☐ Yes ☐ No				
Current Address:				
Mailing Address:				
Primary Insurance:			ID #:	
Secondary Insurance:			ID #:	

Doctor Information

Referring Doctor:	Primary Care Doctor:
How did you hear about Dr. Alvarez?	

List other doctors involved in your care

Doctor: _____ Specialty: _____

Doctor: _____ Specialty: _____

Doctor: _____ Specialty: _____

Reason for Visit

Reason for Visit (current symptoms) _____

Recent Hospitalization? (Last 6 Months) ☐ Yes ☐ No

If yes, please explain: _____

Pharmacy Preference

☐ Local Pharmacy	Name:	Phone:
Local Pharmacy Address:		
☐ Mail-Order Pharmacy	Name:	Fax:
Mail-Order Pharmacy Address:		
Preferred Lab:		

Drug and Food Allergies

Do you have any food allergies? ☐ Yes ☐ No | Do you have any drug allergies? ☐ Yes ☐ No

Medications you are allergic to: _____

Reactions: _____

_____

Other allergies (food, adhesive tape, iodine, latex, etc.): _____

Reactions: _____

_____

Current Medications (please list all prescription, non-prescription, vitamins, etc.)

Current Medication	Dose (Strength)	Dosage (How many & times per day)	Do you need any Refills?
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90

Risk Factors

Do you Use Tobacco? ☐ Yes ☐ Former ☐ Never | If Former, Year Quit:

If Yes, What type?: ☐ Chewing ☐ Cigarettes ☐ Pipe ☐ Smokeless

Packs per day: Years Used: 2nd Hand Smoke Exposure? ☐ Yes ☐ No

Have you ever been diagnosed or are taking medications for the following conditions:

Diabetes: ☐ Yes ☐ No ☐ Unknown | If Yes, Type: ☐ Type 1 ☐ Type 2 | Year Diagnosed:

High Cholesterol: ☐ Yes ☐ No ☐ Unknown

If Yes, Type: ☐ Cholesterol ☐ Triglycerides ☐ Low HDL Syndrome

High Blood Pressure: ☐ Yes ☐ No ☐ Unknown | Year Diagnosed:

Family History of Heart Disease(CAD) prior to age 55: ☐ Yes ☐ No ☐ Unknown ☐ Adopted

Peripheral Vascular Disease (poor circulation in legs): ☐ Yes ☐ No ☐ Unknown

Social History

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed ☐ Life Partner ☐ Other:

Do you have children: ☐ Yes ☐ No | If Yes, How Many Sons: How Many Daughters:

Race: ☐ White ☐ African American ☐ Hispanic/Latino ☐ American Indian/Alaska Native
☐ Asian ☐ Pacific Islander/Native Hawaiian ☐ Other: ☐ Decline

Do you Follow a specific Diet: (check all that apply)
☐ Regular ☐ Diabetic ☐ Low Carb ☐ Low Fat, Low Chol ☐ Low Salt ☐ No Salt
☐ Renal ☐ Vegetarian ☐ No specific diet ☐ Other:

Activity Level: (Exercise)
☐ Sedentary ☐ Occasional ☐ Regular ☐ Active Lifestyle ☐ Physically Unable to Exercise

Exercise Type: (check all that apply)
☐ Aerobics ☐ Cycling ☐ Dancing ☐ Elliptical ☐ Jogging ☐ Physical Therapy
☐ Running ☐ Swimming ☐ Team Sports ☐ Walking ☐ Weight Lifting ☐ Other:

Do you consume Alcohol? ☐ Yes ☐ No ☐ Former If Yes, What Type? ☐ Beer ☐ Wine ☐ Liquor
If Yes, Frequency: ☐ Rarely ☐ Frequently ☐ Social ☐ Occasional ☐ Daily Drinks/Week:

Do you consume Caffeine on a daily basis: ☐ Yes ☐ No Cups/Day:
If Yes, What Type: ☐ Chocolate ☐ Coffee ☐ Soda ☐ Energy Drink ☐ Tea ☐ Tablets
☐ Other:

Drug Use/Abuse: ☐ Yes ☐ Former ☐ Never | If Former, Year Quit:

Advanced Directives: ☐ None ☐ DNR ☐ Healthcare Proxy ☐ Living Will

Primary Language: ☐ English ☐ Spanish ☐ Other:

Family History

☐ Unknown (Unknown Family History) ☐ Adopted (Unknown Family History)

Relationship To Patient	Mother	Father	Brother	Brother	Sister	Sister	Other
Current Age:							
Age at Death:							
Heart Attack:							
Arrhythmia							
Heart Failure:							
Aneurysm:							
Stroke: (CVA)							
High Blood Pressure:							
High Cholesterol:							
Renal Disease							
Cancer Type:							

Other Family History: _____

_____

Past Medical History (Check all that apply)

Respiratory: ☐ COPD ☐ Pulmonary Embolus ☐ Pulmonary Hypertension ☐ Sleep Apnea ☐ Other:

Renal: ☐ End Stage Renal Disease ☐ Renal Artery Stenosis ☐ Renal Insufficiency ☐ Other:

Endocrine: ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Obesity ☐ Other:

Oncology: ☐ Breast Cancer ☐ Skin Cancer ☐ Lung Cancer ☐ Prostate Cancer ☐ Other:

Cardiac: ☐ Arrhythmias ☐ Congestive Heart Failure ☐ Lung Cancer ☐ CAD ☐ ICD ☐ Heart Attack (MI) ☐ Valvular Heart Disease ☐ Coronary Stent/Angioplasty ☐ Pacemaker ☐ Other: _____

Pacemaker Type: _____ Date of Implant/generator change: _____

Date of Heart Attack (MI): _____ Date of CABG/Bypass/Valve Surgery: _____

Stent: _____ Date of Stent: _____

Past Medical History Continued (Check all that apply)

Vascular: ☐ Abdominal Aneurysm ☐ Peripheral Arterial Disease ☐ Carotid Disease ☐ DVT
☐ Thoracic Aneurysm ☐ Varicose Veins ☐ Amputation ☐ Vein Stripping
☐ Aneurysm Repair ☐ Other: _____ Date of Aneurysm Repair: _____

List any other medical conditions: _____

_____

List any other surgeries: _____

_____

Cardiac Testing

Test Type	Yes or No	Date or Year	Location or Hospital	Phone Number
Echo (Ultrasound)	☐ Yes ☐ No			
Electrophysiology (EP)	☐ Yes ☐ No			
Heart Catheterization	☐ Yes ☐ No			
Vascular (vein study)	☐ Yes ☐ No			
Stress Test	☐ Yes ☐ No			
CT/MRI (Type)	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

Other Cardiac Testing: _____

_____

OBSTRUCTIVE SLEEP APNEA SCREENING (OSA)

Patient Name (Printed): _____ Date: _____ Date of Birth: _____

Trouble sleeping can impact your heart health and your blood pressure and increase your risk for stroke and/or sudden death. In an effort to promote cardiovascular health, we are committed to identifying patients with sleep disorders.

Please take a moment to place an "X" in the appropriate column next to each statement below. If you have marked "Yes" next to two or more of these statements, further evaluation of your sleep patterns may be warranted. Your physician will be happy to further discuss this with you during your appointment.

Statement	Yes or No
I snore often or disturb others with my snoring.	☐ Yes ☐ No
I have been told of pauses or stopping breathing during sleep.	☐ Yes ☐ No
I have difficulty waking up or I am sleepy during the day.	☐ Yes ☐ No
I am tired during the day, take naps or fall asleep during activities like reading, working on a computer, or watching TV.	☐ Yes ☐ No
I have headaches when I wake (more than 2 time per week).	☐ Yes ☐ No
I often wake more than 3 times a night.	☐ Yes ☐ No
I often wake to use the bathroom more than twice a night.	☐ Yes ☐ No
I am being treated for at least one of the following conditions: High blood pressure, heart failure, or atrial fibrillation.	☐ Yes ☐ No
I am prescribed to take 3 or more medicines for blood pressure.	☐ Yes ☐ No
I am being followed for diabetes or pre-diabetes.	☐ Yes ☐ No

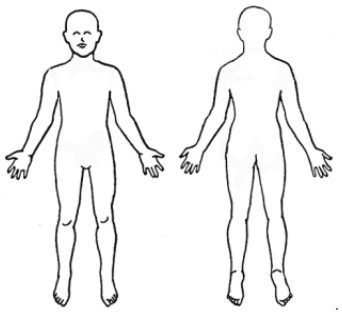
PERIPHERAL VASCULAR DISEASE (PVD) SCREENING

Patient Name (Printed): _____ Date: _____ Date of Birth: _____

Peripheral Vascular Disease (PVD) is a common circulatory problem in which vessels carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your provider can evaluate whether you may be at risk or have symptoms of PVD.

Please circle "Yes" or "No" on the following questions and check all boxes that apply:	
Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation?	☐ Yes ☐ No
Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms? If Yes, Dates: _____	☐ Yes ☐ No
When you walk, do you experience aching cramping or pain in your arms, legs, thighs, or buttocks? If Yes, when do you feel the pain: ☐ After walking 1 block ☐ Climbing a flight of stairs ☐ After walking 100 yards ☐ Walking at increased speed If you answered Yes, circle the area(s) of the body on the diagram below where you feel pain.	☐ Yes ☐ No
If you have pain, does the pain subside with rest?	☐ Yes ☐ No
Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed?	☐ Yes ☐ No
Do you have any painful sores or ulcers on your legs or feet that do not heal?	☐ Yes ☐ No
Are your legs or arms pale, discolored, or bluish?	☐ Yes ☐ No



Check all that apply:	
☐ I have a family history of Diabetes	☐ I have a family history of High Cholesterol
☐ I have a family history of High Blood Press./Hypertension	
☐ I have Coronary Artery Disease (CAD)	☐ I have a family history of Coronary Artery Disease
☐ I have had a Stroke/Mini-stroke/TIA	☐ I have a family history of Stroke/Mini Stroke/TIA

LEG CIRCULATION QUESTIONNAIRE

Please check al that apply:

- ☐ Varicose or spider veins
- ☐ Known leg blood clot
- ☐ Tired, arching, heavy legs
- ☐ Leg pain with sitting or standing
- ☐ Swollen ankles/legs
- ☐ Cramping legs
  - ☐ Worse at night
- ☐ Discoloration of the lower legs
- ☐ Open Sores/ulcers to lower legs
- ☐ Aching legs in bed that feel better with hanging over side of bed or walking
- ☐ around Pain to calf, legs or groin with walking a certain distance
- ☐ Take cholesterol medications
- ☐ Loss of lower leg hair
- ☐ Family history of known vein problems or blood clots to legs
- ☐ Ever been told you have weak or dificult to obtain leg/feet pulses

If you checked any of these above mentioned signs or symptoms you may have a larger underlying problem in your legs. Ask your provider about a special vein and artery ultrasound to be sure.

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION (PHI)

Patient Name (Printed) _____ Date of Birth: _____

I give permission to speak to (name) _____

and (relationship) _____ about my care.

1) Please check one only:

- ☐ I only want my medical information released to myself.
- ☐ I give Tri County Heart Institute and staff authority to release medical information regarding my care.

This authority will be in effect for one (1) year.

2) Emergency Contact Information

Name: _____

Phone Number: _____

Relationship to Patient: _____

3) Please Initial below:

_____ Yes, I give permission to leave messages regarding my test results, appointments, etc.,
At the Following phone numbers: _____ _____

_____ No, do not leave messages regarding my test results, appointments, etc.

Patient Signature: _____ **Date:** _____

Witness: _____

Above Information Remains Unchanged	
Signed By:	Dated:
Signed By:	Dated:

For Official Use Only:

We attempted to obtain written acknowledgment of receipt of this AUTHORIZATION TO RELEASE PHI but could not because:

☐ Individual refused to sign ☐ Communication barrier ☐ Care provided was emergent ☐ Other

Employee Signature: _____ **Date:** _____

PATIENT COMMUNICATION SETTINGS

I, (print name) _____ authorize Tri County Heart to communicate to me via:

- ☐ Voicemail
- ☐ Text message Preferred
- ☐ Home Phone Number _____
- ☐ Preferred Cellphone Number _____
- ☐ Preferred Time to Call:
  - ☐ Morning ☐ Afternoon ☐ Evening
- ☐ Letters
- ☐ E-Mail: _____

This preference will be used when sending communications from Registry screen. The selection has no effect on automated tasks.

What reminders do you prefer:

- ☐ Appointment
- ☐ Lab Results
- ☐ Health Maintenance
- ☐ Prescription Confirmation
- ☑ General Notification

☐ I want to be web enabled.

Note if you select to be web enabled, you will receive communication from our office via your portal, it will be your responsibility to check the portal for these messages

Patient Signature: _____ **Date:** _____

MEDICATION MANAGEMENT

Dear Patient,

Proper management of your medications is very important to your care plan. It is important that we work together to educate you on your medications and that we maintain an accurate medication list.

- Please bring your current medication lists, including dosage and instructions to every office visit with your Healthcare Provider.
  - -Be prepared to provide information about new medications since your last office visit.
- If you have been discharged from the hospital in the last sixty (60) days, it is important to bring your hospital discharge instructions that contain your most recent medication instructions.

Managing Prescription Refills

Tri County Heart Institute is compliant with Electronic Prescription requirements, therefore:

- All refill requests for medication must be made through your local or mail order pharmacy.
- We refill medications prescribed by Tri County Heart Institute Providers only.
- Prescriptions will be refilled during regular business hours only. We are unable to refill prescriptions on weekends and holidays.
- Refills will be made if you have been seen in the past 12 months. If you have not been seen in the past 12 months, a follow up appointment should be made with your Provider.
- If you need a refill authorization (if you are out of refills), you must call your Pharmacy. The pharmacist is in the best position to safely and accurately coordinate the request with our staff.
- Request your refills at least 7 days BEFORE you will run out of medication to allow time for processing of your refill.
- If your prescription has expired, allow at least two weeks for your pharmacy to process the new prescription.
- If your prescription medication requires authorization from your insurance or you use a mail order pharmacy, allow at least 30 days for this process to be completed.

Thank you for your cooperation with following the above instructions to help process all of your medication requests and questions timely and accurately! Our goal is to ensure you understand and take your medications as directed by your physician for your best health benefit.

Consent to Obtain Medical History

I give permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Patient Signature: _____ **Date:** _____

Patient Print Name: _____

Tri - County HEART INSTITUTE

I, (print name) _____ on (date) _____ received the Tri County Heart Institute PA Welcome Packet which includes, but is not limited to:

- New Patient Packet
- Policies and Procedures
- Notice of Privacy Practices
- Patient Rights and Responsibilities
- Financial Policy
- Marketing, Website and Social Media Policy
- Medication Management
- Appointment Protocol

My signature below signifies that I have read and understand the above Policies and Procedures.

Patient Signature: _____ **Date:** _____

Patient Print Name: _____