



CARDIOLOGY

Date: _____

Check in Time: _____

Triage Time: _____

New Patient Health Questionnaire

NAME: _____
LAST FIRST MI

Birth Date: _____

Primary Care Physician (PCP): _____

PCP Contact/Office Phone #: _____

Referring Physician (if different from PCP): _____

Referring Physician Contact /Office Phone # (if different from PCP): _____

Please answer the questions below that apply to your problem:

Why are you here today (problem)? _____
(i.e. chest pain, shortness of breath, heart racing, passing out, etc.)

What causes it: _____
(i.e. walking, exercise, stress, eating, etc.)

When did it start: _____ **Severity:** _____
(Approximate Date) (Scale of 1-10; 10 being most severe)

Location: _____ **Character:** _____
(Where on your body) (i.e. sharp, dull, aching, pressure, racing, etc.)

Duration: _____ **How often:** _____
(Amount of time-minutes/hours it lasts) (# of times day/week/month)

Modifying factors: _____
(What makes it worse and what makes it better)

Other Cardiac Symptoms: (Please check **pif present)**

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Chest pain/Pressure | <input type="checkbox"/> Waking from Sleep w/ SOB | <input type="checkbox"/> Swelling of ankles/legs | <input type="checkbox"/> Palpitations/Skipping Heart |
| <input type="checkbox"/> Short of Breath (SOB) | <input type="checkbox"/> SOB while lying flat | <input type="checkbox"/> Calf/Leg Pain | <input type="checkbox"/> Racing or Pounding Heart |
| <input type="checkbox"/> TIA/CVA | <input type="checkbox"/> Syncope / Fainting | <input type="checkbox"/> Falls | |

Have you seen another Physician in regards to this problem? If yes, whom? _____
When (approximate date)? _____

Have you ever been to a Cardiologist before? If yes, when (approximate date)? _____
Why? _____

Whom? / Location of office (city/state)? _____

Do you have any medical records that may assist us? N / Y Recent lab work in past 6months? N / Y

Past Cardiovascular History:

Do you or have you had any of the following? Please check if YES. (**Risk Factors in Bold**)

- Abnormal EKG
- Aortic Aneurysm/Dissection
- Arrhythmia (fast or slow rhythms)
- Atrial fibrillation /Flutter
- Atrial Septal Defect (ASD)
- Cardiac Bypass Surgery (CABG)
- Cardiomyopathy
- Congenital Heart Disease (Childhood)
- Congestive Heart Failure
- Coronary Artery Disease (Blocked Arteries)
- Coronary Stent (PCI)
- Deep Vein Thrombosis/DVT (Leg blood clot)
- Diabetes Mellitus (type I or type II)**
- Heart Attack
- Heart Surgery (Any other not listed i.e. Valve)
- Hypotension (low blood pressure)
- Hypertension (high blood pressure)**
- Hyperlipidemia (high cholesterol)**
- Murmur (extra heart sound)
- Pacemaker/ICD (Defibrillator)/CRT
- Pericarditis
- Pulmonary Embolism (lung blood clot)
- Pulmonary Hypertension
- Rheumatic Heart Disease
- Stroke/Cerebrovascular disease
- Valve Stenosis (tight valve)
- Valve Regurgitation (leaky valve)
- Vascular Surgery
- Ventricular Septal Defect (VSD)

ANSWER IF APPLICABLE: (Please circle answer)

Past Cardiac Testing History	NO/YES//YEAR	NORMAL / ABNORMAL
24 hour Rhythm Monitor (Holter)	N / Y	NL / ABN
Event Monitor	N / Y	NL / ABN
Echocardiogram	N / Y	NL / ABN
Stress Test	N / Y	NL / ABN
Stress Echocardiogram	N / Y	NL / ABN
Stress Nuclear Test	N / Y	NL / ABN
Cardiac Catheterization	N / Y	NL / ABN
Electron Beam CT/Calcium Score	N / Y	NL / ABN
OTHER:		

MEDICATIONS: List all medications that you are currently taking including non-prescription medications & Herbal remedies. ***(Please Do Not Substitute A List. Please Write Meds Below)***

Medication	Dose	How Often	Approximate Start Date (Month/Year)

ALLERGIES or SENSITIVITY to Medications:

GENERAL PAST MEDICAL HISTORY:

Please Check if Yes.

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Stones/Disease | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GI Bleed/Peptic ulcer disease/AVM | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Pregnancy Induced Hypertension |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Preeclampsia/Eclampsia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis (A or B or C) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD/Lung disease | <input type="checkbox"/> HIV/AIDs | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Smoking (Tobacco) |
| <input type="checkbox"/> Enlarged Prostate (Reduced Urine flow)/BPH | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Erectile Dysfunction (ED) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicose Veins |

PAST SURGICAL HISTORY (MAJOR ONLY: Cardiovascular and General)

Year	Major Surgery

IF FEMALE: Hysterectomy No / Yes **Ovaries Removed** No/ Yes **# of Pregnancies:** _____

FAMILY HISTORY: Questions will pertain to **only** first degree relatives (i.e. parents, brothers/sisters, and children) in your family. Questions will also pertain to age limits: Males 55 or younger, and females 65 or younger. Do any of your first-degree relatives have any of the following? Please circle **Y / N** to the questions listed below, and if yes please explain.

1. Premature heart blockage or heart attack? **Y / N** _____
2. Heart failure or Cardiomyopathy? **Y / N** _____
3. Sudden cardiac death or unexplained death? **Y / N** _____
4. Abnormal heart rhythm? **Y / N** _____
5. Any other cardiac disease not yet mentioned? **Y / N** _____
6. Is your father alive? **Y / N** Age: _____ If deceased, at what age? _____ Cause if known: _____
7. Is your mother alive? **Y / N** Age: _____ If deceased, at what age? _____ Cause if known: _____

SOCIAL HISTORY:

1. What is your occupation? _____ Marital Status: _____
If children, how many? _____
2. Do you or have you ever smoked (cigarette, cigar or pipe)? **Y / N** If so how long (yrs)? _____
How many per/day? _____ If you quit, when? _____
Non-smoking Tobacco (Chew/Snuff)? _____
3. Do you use Alcohol? **Y / N** If yes, type and how much/frequency? (Drinks/wk) 0-5__ 6-10__ >10__
4. Have you ever used illicit drugs (type/how long)? **Y / N** _____
5. Do you exercise? **Y / N** Type of exercise: _____
How often: (Sessions/Week) 0-3: _____ 4-7: _____
How long are your exercise sessions? 10-30mins _____ 31-60mins _____ >60mins _____
7. Any special diet? (i.e. Dash, Adkins, low-fat, high-protein, low-salt ,etc.) _____

8. Do you add salt to food? **Y / N** Daily Caffeine? **Y / N** Daily Soft Drinks/ Sodas? **Y / N**

REVIEW OF SYSTEMS: Please check the following symptoms that have occurred within the last 30 days.
(Leave blank if negative)

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Recent Weight Loss/Gain | <input type="checkbox"/> Clotting Disorder |
| <input type="checkbox"/> Fevers/Chills | <input type="checkbox"/> Excessive Bruising |
|
 | |
| <input type="checkbox"/> Blurred Vision/Double vision | <input type="checkbox"/> Heat/Cold Intolerance |
| <input type="checkbox"/> Poor Dental Health | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Nose/Gum Bleeding | |
| <input type="checkbox"/> Ringing in Ear/Tinnitus | |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Muscle pain/Weakness |
|
 | |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Recurrent Headaches |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Balance Problems/Falls |
|
 | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Slurred Speech |
| <input type="checkbox"/> Heartburn | |
| <input type="checkbox"/> Blood in Stool/Black Stool | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Nausea | |
|
 | |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Urination at night | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Are You Pregnant? | |



Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Saint Joseph's Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of Saint Joseph's Medical Group reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices maybe obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of Saint Joseph's Medical Group may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of Saint Joseph's Medical Group may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked • Personal and Confidential – (We do not mark ours personal and confidential)

With this consent, the office of Saint Joseph's Medical Group may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of Saint Joseph's Medical Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the office of Saint Joseph's Medical Group use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of Saint Joseph's Medical Group may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date



FINANCIAL PAYMENT POLICY

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. We have therefore taken the time to answer some of the most commonly asked questions.

How may I pay?

We accept payment by cash, check, VISA, MasterCard, Discover, and American Express.

What is my financial responsibility for services?

Your financial responsibility depends on a variety of factors, explained below.

<i>If you have.....</i>	<i>You are responsible for.....</i>	<i>Our staff will.....</i>
Commercial Insurance Medicare Medicare Replacement	Payment of the patient responsibility for all office visits, injections, office procedures and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	<u>If the services you receive are covered by the plan:</u> All applicable copays and deductibles are requested at the time of visit. <u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of visit.	File an insurance claim on your behalf.
HMO with which we are not contracted and are not applying for.	Payment in full for office visits, injections, office procedures and other charges at the time of visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility – deductible, copay, non-covered services-at the time of the visit.	File an insurance claim on your behalf.
No Insurance	Payment in full required at the time of service.	

We feel strongly that it is the patient's responsibility to be aware of the requirements and limitations of their own benefits and insurance plans. Please let our office know if your insurance has requirements regarding participating outpatient facility and laboratory. For services rendered in our office and out patient facilities please note that you may also receive bills from other non-Saint Joseph's entities for services rendered in conjunction with your care (i.e, laboratory services).

Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems their services as non-covered will be billed directly for these charges. In exchange for filing your insurance, you agree to provide current insurance information and picture I.D at every office visit. We understand that filling out forms is at times tedious; we do our best to simplify this process.

Co-pays are required at the time of the visit.

Check Policy

We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as a NSF (or for any other reason), you will be assessed a \$35 service fee plus the amount of the original check. You may be required to make future payments using cash, credit card or money order.

No Show Policy/ Late Cancellation Policy

Any time that you miss an appointment in our office or cancel an appointment without giving us 24 hours notice, you will be assessed a \$35-\$250 for no-show/late cancellation fee. The fees for the most common appointments are listed below:

Appointment Type	Fees
Office Visit	\$35-\$50
Physical Exam	\$50
Surgery- Office Procedure	\$125
Surgery- Hospital procedure & Nuclear Testing	\$250

This fee will be your responsibility and must be paid in full prior to your next visit. Dismissal from our practice may result following 3 No Shows.

Application/ Form Completion Fees

A prepayment fee up to \$35 must be paid in full for forms and applications completion such as school physical, sport physical, disability application, and others that do not require you to come to the office.

Medical Record Fees

Charges for Medical Records copies will be determined in accordance with the current State of Georgia Office of Planning and Budget published rates. Minimum costs are approximately \$25.00 as a base fee in addition to a **per page cost of \$1.00.**

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and co-insurance amounts, are my responsibility.

Date

Signature

Printed Name