ACA

ACADEMIC CARDIOLOGY ASSOCIATES, P.C.

PATIENT REGISTRATION / HISTORY

NAME: _____

LAST FIRST MIDDLE

ADDRESS: _____

STREET CITY ZIP

BIRTHDATE: _____

HOME PHONE: _____

WORK PHONE: _____

MOBILE PHONE: _____

SSN: _____

SEX: **M / F**

MARITAL STATUS: **M / S / W / D**

SPOUSE'S NAME: _____ **SPOUSE'S D.O.B.:** _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT INFORMATION:

NAME _____ PHONE NUMBER _____

MAIN REASON YOU ARE BEING SEEN: _____

Please check if you have had any of the following symptoms?		Have you had any of the following procedures?	When?	Where?
Chest pain / pressure / tightness		EKG		
Shortness of breath with activity		Chest X-Ray		
Shortness of breath lying down		Echocardiogram		
Ankle Swelling		Nuclear Stress Test		
Heart racing / fluttering		Holter Monitor		
Passing out (fainting)		Heart Cath / Arteriogram		
Almost passing out		Heart PTCA / Balloon / Stent		
Weight gain / loss		CABG / Heart Bypass / Heart Valve Surgery		
Leg pain		EP Study		
Fatigue		Pacemaker Implant – Type?		
Change in Appetite		Defibrillator		
Cough / Wheezing		Tilt Study		
Dizziness				
Headaches				
Numbness / Weakness				

REVIEW OF SYSTEMS							
Have you had any of the following?							
		Y	**N**			**Y**	**N**
General	Unexplained Fever			**GU**	Kidney Stones		
	Headache / Migraines				Painful or bloody urination		
					If female, are you pregnant?		
Cardiovascular	Atrial Fibrillation				Impotence / sexual problems		
	Congestive Heart Failure (CHF)				Kidney problems		
	Heart Attack				Prostate problems		
	Heart rhythm problem						
	Hypertension (High Blood Pressure)			**MS**	Joint pain		
	Increased cholesterol				Muscle or joint weakness		
	Murmur or valve problem				Muscle pain or cramps		
	Rheumatic fever as a child				Back pain		
	Other Vascular Problems				Cold extremities		
					Arthritis		
HEENT	Eye Disease						
	Hearing Loss			**Skin**	Rash		
	Sinus problems				Itching		
	Nose Bleed				Varicose veins		
	Bleeding gums				Skin issues		
	Cataract						
	Glasses / contacts			**Neuro**	Frequent / recurring headaches		
					Numbness or tingling		
Respiratory	Spitting up blood				Weakness on one side		
	Emphysema				Tremor		
	Asthma				Difficulty speaking		
	Cough				Head Injury		
	Wheezing				Stroke		
					Vertigo		
GI	Nausea / Vomiting						
	Frequent diarrhea			**Endo / Hemo**	Thyroid problem		
	Constipation				Other hormone problems		
	Hepatitis				Heat / cold intolerance		
	Bloody stools				Bleeding		
	Indigestion				Easy bruising		
	Stomach ulcers				Anemia		
GI (cont.)	Acid Reflux	**Y**	**N**	**Endo / Hemo (cont.)**	Blood transfusion	**Y**	**N**
	Colitis				HIV		
	Diverticulitis / Diverticulosis				Blood Clots		
	Gallbladder disease				B-12 Definciency		
	Irritable Bowel Syndrome (IBS)				Cancer – what type?		
	Ulcers				Diabetes		
					If Diabetic, are you on isulin?		
Psych	Depression of anxiety				Lupus		
	Seizures				Lymphoma		
	Insomnia						
	Panic attacks						

Habits:	Yes	No	
Do you exercise?			If yes, how often?
Do you smoke?			If yes, how much?
Did you ever Smoke?			If yes, when did you quit?
Do you drink alcohol (beer, wine, liquor)?			If yes, how much?
Do you use street drugs?			If yes, what?

(NOTE: Please Obtain Medical Records)

Hospitalizations / major illnesses	Date / Where	Surgeries	Date / Where

Do you have allergies to:	List Medication Allergies / Reaction	List Food Allergies / Reaction	List Seasonal Allergies / Reaction
Dye Allergy (Iodine / Shellfish, X-Ray contrast)			
Latex Allergy			
Any Medications			

MEDICATION LIST: List any pills or medications (Please include vitamins, herbs, or over the counter medications)

NAME	DOSE	TIMES PER DAY

Family History:	If Living: Age / Medical Problem	If Deceased: Age / Cause of Death
Mother		
Father		
Siblings		
Children		