COMPREHENSIVE CARDIOLOGY
Patient Demographics

☐ Dr. Nguyen ☐ Dr. Sudhakar ☐ Dr. Uricchio Date _____

Name: _____Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

E-Mail Address: _____

Marital Status: S M D W SSN: _____-____-_____

Emergency Contact: _____ Relation: _____
Phone # _____

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Who referred you to us? _____ PCP :_____

Phone #: _____ Fax #:_____

Guarantor Information (If other than yourself)

Name : _____Date of Birth:_____
Relationship: _____ SSN : ___-__-___ Home #: _____

Work # :_____ Cell # : _____

Address: _____ City: _____ St: _____ Zip: _____

Employer: _____

Primary Insurance

Insurance Co: _____ ID #:_____ Group #: _____

Address: _____ St.: _____ Zip : _____

Secondary Insurance

Insurance Co: _____ ID # : _____ Group #:_____

Address: _____ St.: _____ Zip: _____

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Preferred Pharmacy

Name:_____Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PLEASE SIGN THE FOLLOWING STATEMENTS:

Assignment of Benefits: I authorize payment of medical benefits to the named provider for professional services rendered.

Signature: _____ Date: _____

Release of Information: I authorize the release of information necessary to process the claim.

Signature: _____ Date: _____

Test Results: I hereby authorize my test results to be left on the answering machine at the following number

_____.

Signature: _____ Date: _____

Medication Records: I hereby authorize Dr. Nguyen, Dr. Sudhakar and/or Dr. Uricchio to have access to my medication list through electronic pharmacy records.

Signature: _____ Date: _____

Data Sharing: I hereby agree to having my data shared with my Physicians.

Signature: _____ Date: _____

Your office visit and testing will be sent to your Referring Physician and/or your Primary Care Physician unless you specify otherwise.

I hereby authorize my test results to be given to my PCP/Referring Physician and the following people:

_____ _____

_____ _____

_____ _____

I have been offered a copy of the patient's rights and privacy act.

Signature: _____ Date: _____

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_____

Date: _____

Patient Name: _____ Age: _____

Who referred you? _____

Reason for seeing Dr. Nguyen, Dr. Sudhakar and/or Dr. Uricchio?

_____

Check all the following you have experienced:

Cardiovascular:

_____CHEST PAIN **_____ RHEUMATIC FEVER** **_____ PALPITATIONS**

_____ EASY FATIGABILITY **_____IRREG HEART BEATS** **_____ANKLE SWELLING**

_____ HEART ATTACK **_____ HEART MURMUR** **_____ANGINA**

_____ ENLARGED HEART **_____CONGESTIVE HEART FAILURE** **_____ABNORMAL EKG**

_____ DIABETES **_____HIGH BLOOD PRESSURE** **_____CHEST INJURY**

_____ ELEVATED CHLOLESTROL **_____NEED TO URINATE AFTER BEDTIME**

_____SLEEP ON MORE THAN ONE PILLOW **_____ OTHER LIPID ABNORMALITY**

_____ARTERIOSCLEROSIS (HARDENING OF THE ARTERIES)

_____ACHING IN LEGS WHEN WALKING **_____ABNORMAL CHEST X-RAY**

RESPIRATORY:

SHORTNESS OF BREATH WITH:

_____ACTIVITY **_____MINIMAL EXERTION** **_____ AT REST**

_____AT NIGHT **_____WHEN LYING FLAT** **_____FREQUENT COLDS**

_____COUGHING UP BLOOD **_____RESPIRATORY DISEASE** **_____ FREQUENT COUGH**

_____PROLONGED COUGH **_____BLOOD CLOT TO LUNG** **_____ASTHMA**

_____EMPHYSEMA **_____ BRONCHITIS**

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ENDOCRINE:

_____THYROID PROBLEMS _____DIABETES _____GOITER

_____ HORMONE THERAPY _____ GOUT

_____FREQUENT THIRST _____FREQUENT URINATION

HEAD, EARS, EYES, NOSE AND THROAT:

_____NOSE BLEEDS _____FREQUENT SORE THROAT

_____DIZZINESS/LIGHTHEADEDNESS _____SEVERE OR UNUSUAL HEADACHES

_____RECENT VISION CHANGES

Nervous System:

_____SEIZURES _____MOOD CHANGES _____MEMORY LOSS

_____ANXIETY/DEPRESSION _____ DIFFICULTY WITH SPEECH

GASTROINTESTINAL:

_____JAUNDICE _____HEPATITIS _____DIVERTICULITIS

_____HEMORRHOIDS _____DIARRHEA _____BLACK STOOLS

_____RECENT NAUSEA/VOMITTING _____HEARTBURN/INDIGESTION

_____RECENT ABDOMINAL PAIN _____STOMACH/DUODENAL

_____RECENT CHANGE IN BOWEL HABITS _____BRIGHT RED BLOOD IN STOOLS

_____PROBLEMS WITH CONSTIPATION _____GALL BLADDER DISEASE

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URINARY:

_____KIDNEY INFECTIONS _____KIDNEY STONES _____INCONTINENCE

_____URGENCY _____BLOOD IN URINE _____PROSTATE

_____UNUSUAL PATTERN OF URINATION _____ URINE COLOR CHANGES

EXTREMITIES, BONES AND JOINTS:

_____COLDNESS _____DEFORMITIES _____CRAMPING

_____WEAKNESS _____REDNESS/DISCOLORATION

_____STIFFNESS, LIMITATION OF MOVEMENT _____PAIN INCLUDING BACK PAIN

CURRENT MEDICATIONS:

NAME	DOSE	FREQUENCY	DATE STARTED

MEDICATION ALLERGIES:

_____

_____

PLEASE LIST ANY MEDICAL CONDITIONS NOT LISTED:

_____

_____

_____

_____

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PLEASE LIST ANY PREVIOUS HOSPITALIZATIONS OR SURGERIES:

DATE HOSPITAL DR. DIAGNOSIS_____
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HAVE YOU EVER SMOKED? _____YES ____NO _____PACKS PER DAY

DO YOU SMOKE NOW? _____YES ____NO _____YEAR QUIT

ARE YOU REGULARILY EXPOSED TO SECOND HAND SMOKE? ____YES ___NO

DO YOU OR DID YOU DRINK ALCOHOL? _____YES ____NO

IF YES, HOW MUCH/HOW OFTEN? _____IF QUIT, WHEN ? _____

HOW MUCH COFFEE (CAFFEINE) DO YOU DRINK? _____

ARE YOU ON A REGULAR EXERCISE PROGRAM? ____YES ____NO

IS YOUR OCCUPATION STRESSFUL? ____YES ____NO

DO YOU HAVE REGULAR MEDICAL CHECK UPS? ____YES ____NO

ARE YOU ON ANY DIETARY RESTRICTIONS ? SALT Y/N SWEETS Y/N CAFFEINE Y/N

CHLOLESTROL Y/N OTHER:_____

Date of last flu shot_____ Pneumo shot _____

Date of last eye exam_____ colonoscopy_____ mammogram_____

RELATIVE	ALIVE/ WELL	HEART DISEASE	DIABETES	HYPERTENSION	CANCER	STROKE
FATHER (AGE)						
MOTHER (AGE)						
GRANDFATHER						
GRAND MOTHER						
UNCLE						
AUNTS						
SIBLINGS						
CHILDREN						