ADVANCED CARDIOVASCULAR CARE CENTER, P.A.

9200 Pinecroft, Suite 460, The Woodlands, Texas 77380
837 FM 1960 Road West, Suite 101, Houston, Texas 77090
(281) 866-7701 (281) 866-7705

PATIENT INFORMATION FORM
2010

WHO IS YOUR PRIMARY/FAMILY/REFERRING DOCTOR? _____

NAME: LAST _____ FIRST _____ MIDDLE _____

ADDRESS _____

CITY _____ ST_____ ZIP_____

PHONE: HOME _____ CELL_____ WORK _____EXT_____

SEX ☐MALE ☐FEMALE D.O.B._____ SOC SEC# _____-_____-_____

☐STUDENT ☐RETIRED ☐EMPLOYED WHERE _____ MARITAL STATUS_____

SPOUSE NAME_____ D.O.B._____ SOC SEC#_____-_____-_____

SPOUSE EMPLOYER_____ SPOUSE WORK PHONE_____

LOCAL PHARMACY _____ LOCAL PHARMACY PHONE_____

MAIL ORDER PHARMACY _____ MAIL ORDER PHARMACY PHONE _____

E-Mail Address _____

PRIMARY INS_____ PHONE_____
CLAIM
ADDRESS_____

ID# _____ GROUP#_____

INSURED NAME _____ D.O.B. _____

SECONDARY INS_____ PHONE_____
CLAIM
ADDRESS_____

ID# _____ GROUP#_____

INSURED NAME _____ D.O.B. _____

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Name: _____ Date of Birth: _____ Date: _____

Address: _____

Phone: Home_____ Work_____ Cell_____ Pharmacy_____

PATIENT'S PERSONAL HISTORY

All information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your physician in decisions regarding your care.

1. What is your primary reason for seeing the doctor? (Please list all symptoms, how long you have had these symptoms, and what makes your symptoms better or worse.)

_____
_____
_____

2. Who referred you to us? _____ Who is your primary care physician? _____

3. What other health complaints do you have?

_____
_____
_____

4. List any operations or serious illnesses that you have had. (Please give approximate date of surgery or onset of illness.)

_____ _____
_____ _____
_____ _____
_____ _____

5. Have **you** ever had any of the following? (If any box is marked, please specify age at onset.)

- ❑ Heart Attack _____ □Bypass_____ □Stent_____
- ❑ Heart Murmur _____
- ❑ High Blood Pressure _____
- ❑ Congestive Heart Failure _____
- ❑ Pacemaker or Defibrillator _____
- ❑ Diabetes _____
- ❑ Stroke _____
- ❑ Lung Disease _____
- ❑ High Cholesterol _____
- ❑ Valve Disorder _____

6. Has **anyone in your immediate family** ever had: (If any box is marked **please** specify family member, age at onset of illness and current age **or** age at death.)

- ❑ Heart attack _____
- ❑ Heart murmur _____
- ❑ High blood pressure _____
- ❑ Congestive heart failure _____
- ❑ Congenital heart disease _____
- ❑ Diabetes _____
- ❑ Stroke _____
- ❑ Lung disease _____
- ❑ High cholesterol _____

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Name: _____ **Age:** _____

PATIENT'S REVIEW OF SYSTEMS

(Please answer yes or no)

7. Are you now or have you in the last 6 months experienced lightheadedness or dizziness? _____
8. Chest pain a.) with exertion? _____ b.) at rest? _____
9. Shortness of breath a.) with exertion? _____ b.) at rest? _____
10. Wake from sleep because of shortness of breath? _____
11. Pain or swelling in legs? _____
12. Sleeplessness or tiredness? _____
13. Sleep with head elevated to facilitate breathing? _____
14. Do you have headaches? _____
15. Ringing in ears? _____
16. *LADIES:* When was your last menstrual period? _____

MEDICATION PROFILE

17. List all medications you are presently taking:

Medication	**Dosage**	**Frequency**
_____	_____**mg**	_____
_____	_____**mg**	_____
_____	_____**mg**	_____
_____	_____**mg**	_____
_____	_____**mg**	_____
_____	_____**mg**	_____
_____	_____**mg**	_____
_____	_____**mg**	_____

18. Do you have any drug or food allergies? If yes, please list allergies and reaction.

_____

* Are you allergic to Iodine? Yes / No

PATIENT'S SOCIAL HISTORY

19. Do you currently smoke? _____ *Packs per day* _____
20. Have you ever smoked? _____ *Year quit or age when quit* _____
21. Please specify the number of cups per day you drink of each of the following caffeinated drinks:
    a. Coffee _____
    b. Tea _____
    c. Soda _____

22. Do you regularly drink: If yes:
    a. Beer _____ Number of drinks per day _____
    b. Wine _____ Number of drinks per day _____
    c. Liquor _____ Number of drinks per day _____

23. Have you ever had a drug problem or are you using recreational drugs now? _____
24. Occupation: _____
25. Is there much tension or pressure in your job? _____
26. Marital status: _____
27. Number of children: _____
28. Permission to leave message on answering machine _____ Yes _____ No

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Name: _____ Date: _____

Review of systems

Please check all symptoms that you are having.

Cardiovascular
_____Murmur
_____Irregular Heart Rhythm
_____Palpitations
_____Squeezing of the chest
_____Chest Pain
_____Chest tightness or discomfort
_____Shortness of breath
_____Shortness of breath with exertion
_____other:_____

Ears, Nose
_____Hearing loss
_____Ringing in ears
_____Abnormal mucous membranes

Eyes
_____Blurred or Double vision
_____Contacts or Glasses

Psychiatric
_____Anxiety problems
_____Depressive symptoms
_____Personality or Mood changes

Integumentary
_____Edema - Swelling
_____Sweating
_____Bruising
_____Skin lesions
_____Skin cancer
_____Rash or itching on skin

Gastrointestinal
_____Abdominal pain
_____Weight gain
_____Weight loss
_____Change in appetite
_____Nausea or Vomiting
_____Diarrhea or Constipation
_____Indigestion or Heartburn
_____Reflux

Musculoskeletal
_____Arthritis
_____Back or Neck pain
_____Leg pain
_____Arm pain
_____Gout

Neurological
_____Gait disturbance trouble walking
_____Seizures
_____Confusion or Memory loss
_____Weakness or Fatigue
_____Numbness or Tingling
_____Headaches
_____Dizziness
_____Syncope (Passed out)
_____Swallowing difficulties
_____Difficulties in Speech

Respiratory
_____Congestion or Wheezing
_____Cough

Genitourinary
_____Incontinence
_____Frequent urination
_____pain or burning with urination
_____Blood in Urine

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Authorization for Release of Medical Records To:

By signing this form, I *_____ authorize **Advanced Cardiovascular Care Center** to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the **person(s) or entity** listed below.

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

***Release my protected health information to the following person(s)/entity:**

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

The reasons or purposes for this release of information are as follows:

_____

_____

_____

Patient Signature [or parent, guardian or legal representative]:

*_____ Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

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Authorization Form for Release of Protected Health Information

Patient Name: _____

Contact Information: May we leave messages in your voice mail: ☐ Yes or ☐ No.

Below please list any family member or Physicians we may share your medical information with.
Release my protected health information to the following person(s)/entity:

Name: _____ Phone: _____
Street: _____ City: _____ State: _____ Zip: _____

Name: _____ Phone: _____
Street: _____ City: _____ State: _____ Zip: _____

Name: _____ Phone: _____
Street: _____ City: _____ State: _____ Zip: _____

This authorization shall be in force and effective until the following event and/or date: _____

_____

The reasons or purposes for this release of information are as follows:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Babu Varughese (Privacy Officer), 9200 Pinecroft, Suite 460, The Woodlands, Texas 77380 281-866-7701
I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative _____ Date: _____

Name of Patient or Personal Representative: _____ Description of Personal Representative's Authority
By signing this form, I authorize you to use and disclose the protected health information described below

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

For office staff use only:
If the patient refuses to a written acknowledgement of the Notice of Privacy Practice, please indicate your comments:

_____

Name: _____ Date: _____

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Authorization for Release of Medical Records (from another facility to ACCC)

Patient Name: _____

Birth Date: _____ Social Security Number: _____

Below please list names of any Doctors you have seen or any Hospitals you have been in recently. We will request records for your chart.

(Please list all Doctors and Hospitals we need to get records from)

I hereby authorize: _____

_____

_____

To release all of the information contained in my medical records to:

Annie T. Varughese, M.D., F.A.C.C.
Kozhaya C. Sokhon, M.D.
9200 Pinecroft suite 460
The Woodlands, Texas 77380
Telephone: (281) 866-7701
Fax: 281-866-7705

*The information being released will only be used for medical purposes.
*This authorization is valid for one year from the date of signing.
*The patient or his/her representative may revoke this consent at any time.

_____

Signature of Patient or Representative Date

PROHIBITION OF REDISCLOSURE: This information is being disclosed from medical records whose confidentiality is protected by law. Any further disclosure of this information must be by written consent of the person to whom it pertains. A general authorization for release of medical other information if held by another party is not sufficient for this purpose. The party to whom this consent is addressed releases this information by reason of the signature noted above and is not responsible for redisclosure for any purpose.