ADVANCED CARDIOVASCULAR CARE CENTER, P.A.

25311 INTERSTATE 45 NORTH, BUILDING NO 06, THE WOODLANDS,
TEXAS 77380 (281) 866-7701 PHONE (281) 866-7705 FAX

PATIENT INFORMATION FORM

WHO IS YOUR PRIMARY/FAMILY/REFERRING DOCTOR? _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INIT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ 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 #: _____ CELL: _____

LOCAL PHARMACY: _____ LOCAL PHARMACY PHONE: _____

MAIL ORDER PHARMACY: _____ MAIL ORDER PHARMACY #: _____

E-MAIL ADDRESS: _____

PRIMARY INSURANCE: _____ PHONE: _____

CLAIM ADDRESS: _____

ID #: _____ GROUP #: _____

INSURED NAME: _____ D.O.B: _____

SECONDARY INSURANCE: _____ PHONE: _____

CLAIM ADDRESS: _____

ID #: _____ GROUP #: _____

INSURED NAME: _____ D.O.B: _____

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PATIENT'S PERSONAL HISTORY

NAME: _____ D.O.B: _____ DATE: _____

All information contained here will not be release 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, hospitalizations, and 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 of 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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PATIENT'S REVIEW OF SYSTEMS

NAME: _____ D.O.B: _____ DATE: _____

(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
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? YES / NO 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. Occupations _____
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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REVIEW OF SYSTEMS

NAME: _____ D.O.B: _____ DATE: _____

Please answer yes or no below all symptoms:

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

Respiratory

_____ Congestion or Wheezing
_____ Cough

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

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 Code:**_____

The reasons or purpose 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: _____ *May we leave messages in your voicemail? ☐ Yes or ☐ No

Below please list any family member or Physician 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: _____

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), 25311 Interstate 45 North, 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 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 sign 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

NAME: _____ D.O.B: _____

SOC SEC # _____-_____-_____

I hereby authorize the release of information contained in my medical records to:

Annie Varughese, M.D, F.A.C.C
Alan Mobley, M.D, F.A.C.C

(281) 866-7701 PHONE (281) 866-7705 FAX (Woodlands)
(936) 756-5866 PHONE (936)756-5703 FAX (Conroe)

_____ All Medical Records
_____ Cardiac Testing
_____ EKG
_____ Recent Labs
_____ Recent Progress Notes

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

_____	_____	_____
Printed Name	Signature	Date

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MEDICARE AND COMMERCIAL INSURANCE SIGNATURE ON FILE

I hereby request that payment of authorized Commercial Insurance and/or Medicare benefits be made on my behalf to Advanced Cardiovascular Care Center. Dr. Annie T. Varughese or Dr. Alan Mobley for any services furnished me by the company listed. I authorize any holder of Medical Information about me to release to Medicare and/or Commercial Insurance and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature below requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined of the Medicare Carrier as full charge, and the patient is responsible for only the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Commercial Insurance and/or Medicare Carrier.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

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Circle your Physician: Dr. A. Varughese Dr. A. Mobley

General Health Questions: Autonomic Nervous System Test

Do you frequently have or have you been told that you have any of the following:

Heart and Lung Problems ……..…… Y / N
Circle those that apply: **Chest Pain High or Low Blood Pressure High Cholesterol Rapid or Slow Heart Rate Past History of Heart Attack Difficulty Breathing Congestive Heart Failure (CHF) Chronic Obstructive Pulmonary Disease (COPD)**

Digestive Disturbances…… Y / N
Circle those that apply: **Irritable Bowel Syndrome (IBS) Constipation Diarrhea Nausea Acid Reflux (GERD)**

Exercise Intolerance…… Y / N
Excessive Fatigue…… Y / N
Thyroid Disorders…… Y / N
Kidney or Renal Disease…….. Y / N
Feelings of anxiety, depression or Malaise (a general feeling of "un-well", discomfort, uneasiness)…… Y / N
Seizures, Migraines or Other Headaches……. Y / N
Chronic Pain Syndromes…….. Y / N
If so circle all that apply: **Chronic Fatigue Syndrome (CFS) Reflex Sympathetic Dystropy (RSD) Fibromyalgia Other:**

Neurocognitive Symptoms: Cognitive Test

1. Are you over the age of 65? ……... Y / N
2. Do you have problems with memory, thinking, with judgments or trouble making decisions? ……. Y / N
3. Do you have less interest in hobbies and activities?..... Y / N
4. Do you repeat the same things over and over again (i.e. questions, stories or statements)? …….. Y / N
5. Do you have trouble learning how to us a tool, appliance or gadget? …… Y / N
6. Do you forget the correct month or year? ……... Y / N
7. Do you have trouble handling complicated financial affairs (i.e. income taxes, paying bills)? ……. Y / N
8. Do you have trouble remembering appointments? ……. Y / N
9. Do you have daily problems with thinking and/or memory? ……. Y / N

Neurological and Musculoskeletal Symptoms: Electromyography/Nerve Conduction Velocity Test EMG/NCV

Do you have leg pain during activity that goes away with rest?..... Y / N
Do you often have leg cramps? ……. Y / N
Do you have wounds on your legs that heal very slowly? ……. Y / N
Do you experience ANY of the following (please circle those that apply):
Radiating pain, Numbness, Tingling, Burning, Coldness, Sharp or Dull Pain
( ) in the neck, shoulders, arms or hands (upper extremities)……. Y / N
( ) in the low back, hips or legs (lower extremities)…… Y / N
Have you experienced loss of motion or weakness in your neck, shoulders, arms or hands? …… Y / N
Have you experienced loss of motion or weakness in your low back, hips or legs?..... Y / N

Vestibular/Balance Symptoms: Videonystagmography Test VNG

Do you ever lose your balance or feel dizzy or unsteady?..... Y / N
Do you feel unsteady when walking or climbing stairs?..... Y / N
Have you fallen more than once in the past year?..... Y / N
Does dizziness or imbalance problems interfere with our job or your household responsibilities? ……... Y / N
Do you feel dizzy while sitting down or rising from a seated or lying position? ……... Y / N

Sleep Disturbance Symptoms Sleep Study *NO Medicare/BCBS/Humana Insurances accepted

Have you been told that you snore loudly?..... Y / N
Do you stop breathing, choke, or gasp for air during sleep? ……... Y / N
Do you tend to get drowsy during the day when you are not occupied?..... Y / N
If awakened, do you find it difficult to go back to sleep? ……... Y / N
Do your legs kick at night and interfere with your sleep?..... Y / N
Approximately, how many hours of sleep do you get most nights? ……

This History Update, which is included in your medical record, lists symptoms and other factors that contribute to your physician's decision making in the recommendation of one or more diagnostic studies. Upon review and approval by your physician an outside diagnostic firm partnered with your physician will contact you to schedule your test(s).

Patient Signature: _____ *Date:* _____

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Answer the following questions to find out if you are at risk for Obstructive Sleep Apnea.

STOP

S (snore)	Have you been told that you snore?	Yes / No
T (tired)	Are you often tired during the day?	Yes / No
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes / No
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	Yes / No

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are a moderate to severe risk of Obstructive Sleep Apnea, complete the final four questions.

BANG

B (BMI)	Is your body mass index greater than 28?	Yes / No
A (age)	Are you 50 years old or older?	Yes / No
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	Yes / No
G (gender)	Are you a male?	Yes / No

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.