PRESCOTT CARDIOLOGY
304 Ainsworth Dr. Suite 102, Prescott, AZ 86305 - PH: (928) 776-0601 - FAX: (928) 776-0620 - www.prescottcardio.com

Dear New Patient:

Welcome! We look forward to providing you with the highest quality of care, service, and respect.

Please complete the attached forms and mail them back in the enclosed, stamped envelope.

If your appointment is **in less than five days** from receipt of this packet, please bring the completed forms with you to your appointment rather than mailing them back to us.

Please arrive 15 minutes early if you have completed all attached forms. If you have NOT completed the forms, please arrive 30-45 minutes early.

When you come to our office for your appointment, be sure to bring the following with you:

1. **Your Insurance Card(s)**
2. **Your Photo Identification**
3. **ALL prescription medication bottles (for your safety, we need to visually verify what you have written on the forms)**
4. **Your Copay, Co-Insurance, and/or Deductible**

If you have any questions, please call us at 928-776-0601 and we will be happy to assist you.

Thank you for choosing us for your cardiovascular needs!

Douglas W. Rothrock, MD -and- Stephen Stuart, MD

<u>YOUR PERSONAL HEALTH INFORMATION</u>

At Prescott Cardiology we strive to protect your privacy. Therefore, please let us know what you prefer below. Thank you for your kind cooperation!

DATE:_______________

PATIENT'S NAME:____

PATIENT'S DATE OF BIRTH:_________________________________

I wish to be contacted in the following manner (check ALL that apply):

_____Home Phone (list your home ph #)______________________

_____Cell Phone (list your cell ph #)________________________

_____By Letter to my home address

_____By Fax (list your fax #)______________________________

_____By Email (list your email address)______________________________________

_____Call Me at Work (list your work #)_____________________________

Please tell us how we may leave a message for you (check ALL that apply):

_____Leave message with detailed information as to reason for calling

_____Leave message with call-back # only - no other details

_____You may leave a message on any of my answering machines/voicemails on my phone numbers.

Please tell who may receive information regarding your protected health information? (check ALL that apply):

_____**Spouse/Significant Other**

Please list his or her name:________________________________

Please list his or her phone number:_________________________

_____**Child(ren)**

Please list his or her name:________________________________

Please list his or her phone number:_________________________

_____**Other Person/Persons**

Please list his or her name:________________________________

Please list his or her phone number:_________________________

*Please Note: Notes from your medical care provided at Prescott Cardiology will be sent to your primary care physician and/or the physician who referred you to us **<u>UNLESS</u>** you instruct us to do otherwise. Please check one of the two choices below:*

____I authorize you to send/request my protected health information to/from other healthcare providers who may be involved in my treatment directly or indirectly.

____**DO NOT** send my protected health information to my primary care physician.

____ ____________

PATIENT'S SIGNATURE or AUTHORIZED REPRESENTATIVE **DATE**

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DATE: _____

Doctor:_____
Apt Date:_____
Apt time:_____
Account#:_____

****

NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY

Please check all that apply:

_____ Abdominal aneurysm	_____ Clogged Arteries	_____ Poor Blood Circulation
_____ Abnormal EKG	_____ Congestive Heart Failure	_____ Pulmonary Hypertension
_____ Abnormal Heart Valve	_____ Diabetes	_____ Rapid Heart Rate
_____ Abnormal Stress Test	_____ High Blood Pressure	_____ Shortness of Breath
_____ Blood Clot in Lung(s)	_____ Heart Attack	_____ Stroke
_____ Bundle Branch Block	_____ Irregular Heartbeat	_____ Coronary Artery Disease
_____ Cardiac Arrest	_____ Pacemaker	_____ Enlarged Heart

Do you accept blood transfusions? _____ Yes _____ No

Do you have a Medical Power of Attorney or Living Will? _____ Yes _____ No

FAMILY MEDICAL HISTORY

If you were adopted or do not know your family history, please check here: _____

Please write in space provided any BLOOD RELATIVES that had any of the following:

Abdominal aneurysm _____ Heart Attack _____

Blood Clot in Lung(s) _____ Heart Murmur _____

Bypass Surgery _____ Heart Valve Replacement_____

Cardiac Arrest _____ High Blood Pressure _____

Clogged Arteries _____ Irregular Heartbeat _____

Congestive Heart Failure _____ Pacemaker _____

Coronary Artery Disease _____ Poor Circulation _____

Diabetes _____ Stroke _____

Enlarged Heart _____ Sudden Death _____

Problems with Anesthesia _____

PRESCOTT CARDIOLOGY

DATE: _____

NAME: _____ **DOB:** _____

SOCIAL HISTORY

Please answer the following questions:

Do you smoke? Yes _____ No _____ How much per day? _____

Do you consume alcoholic beverages? Yes _____ No _____

On average, how many alcoholic beverages do you drink per week? _____

Do you consume foods/drinks that contain caffeine? Yes _____ No _____

On average, how many caffeinated drinks do you have per day? _____

Note: If you have quit any of the above, please write on the line below approximately how long ago you quit:

Smoking _____

Alcohol _____

Caffeine _____

What is/was your occupation? _____

Marital Status:

_____ Married _____ Divorced _____ Single _____ Widowed _____ Separated

With whom do you live? _____

How much exercise do you do, on average, each week? _____

CARDIAC SURGICAL HISTORY

If you have had <u>any</u> of the following surgeries, please tell where the procedure was performed and your best estimate of when it was performed.

TYPE OF SURGERY	DATE	NAME OF SURGEON AND/OR FACILITY
Stent placed in heart	_____	_____
Pacemaker Placement	_____	_____
Bypass Surgery	_____	_____
Had a heart valve replaced	_____	_____
Had a catheterization/angio	_____	_____
Other: _____	_____	_____

PRESCOTT CARDIOLOGY

DATE: _____

NAME: _____ **DOB:** _____

Are you presently or have you recently experienced any of the following:
(Please circle all that apply)

Chest Pain or Chest Pressure

Date this pain or pressure began: _____

How long does this pain/pressure lasts (once it occurs): _____

What makes this pain/pressure worse: _____

What makes this pain/pressure better: _____

Chest Tightness

Date this chest tightness began: _____

How long does chest tightness last (once it occurs): _____

What makes this chest tightness worse: _____

What makes this chest tightness better: _____

Shortness of Breath

Date this began: _____

How long does this last (once it occurs): _____

What makes this worse: _____

What makes this better: _____

Visual Disturbances

Date this began: _____

How long does this last (once it occurs): _____

What makes this worse: _____

What makes this better: _____

Lightheadedness/Dizziness

Date this began: _____

How long does this last (once it occurs): _____

What makes this worse: _____

What makes this better: _____

Loss of Balance

Date this began: _____

How long does this last (once it occurs): _____

What makes this worse: _____

What makes this better: _____

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Do you experience pain when walking in your:

Buttocks:	When did this first start?	_____
	How long does it last?	_____
	What makes it worse?	_____
	What makes it better?	_____
Thighs:	When did this first start?	_____
	How long does it last?	_____
	What makes it worse?	_____
	What makes it better?	_____
Calves:	When did this first start?	_____
	How long does it last?	_____
	What makes it worse?	_____
	What makes it better?	_____

HOSPITALIZATIONS

Please list any illnesses/disease/serious injuries/accidents that required hospitalization:

DATE	REASON FOR HOSPITALIZATION	HOSPITAL	TREATING DOCTOR

Please comment on any other pertinent medical condition/treatment not previous addressed:

_____

_____

_____

_____

_____

_____

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NAME: _____ **DOB:** _____

MEDICATION ALLERGIES

Are you allergic to any medications? _____ Yes _____ No

If so, please list the medications you are allergic below:

MEDICATION	WHAT REACTION DOES IT CAUSE

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TODAY'S DATE: _____ **YOUR DATE OF BIRTH:**_____

PATIENT'S NAME: _____

Dear Patient: Please complete this form by listing ALL prescription medications and supplements that you currently take. We have provided an example on the first line below of how this form should be completed. Thank you.

NAME OF MEDICATION	DOSAGE	NUMBER OF TABLETS TAKEN EACH DAY	PRESCRIBED BY WHOM
Vitamin X	500 mg	Twice	Dr. John Doe

_____
PATIENT'S SIGNATURE or HIS/HER REPRESENTATIVE'S SIGNATURE