ASHCHI HEART & Vascular Center

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NEW PATIENT REGISTRATION FORM

Today's Date: _____

Email address: _____

Last Name:_____ First Name: _____ MI_____

Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ DOB: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

If married, Spouse's name: _____

Do we have permission to:
Leave a message on your answering machine at home? ☐ YES ☐ NO
Leave a message at your place of employment? ☐ YES ☐ NO
Discuss your medical condition with any member of your household? ☐ YES ☐ NO

If yes, whom? _____Relationship: _____

EMERGENCY CONTACT
Name: _____ Relationship: _____
Phone: _____
Address: _____City: _____ State: _____ Zip:_____
Occupation: _____

Cardiovascular Specialists seen in the past? Who? _____ When?_____
Referring Physician: _____Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

PLEASE LIST CURRENT PHYSICIANS YOU SEE
Family/Primary Care: _____ Phone: _____
Pulmonologist: _____ Phone: _____
Nephrologist: _____ Phone: _____
Oncologist: _____ Phone: _____
Dialysis: M T W TH F S Location: _____ Phone: _____

We are required to request the following information. The Federal Administrative Reporting Agency requests that we provide this information for statistical purposes only. Your Participation is optional. Please take a moment to complete the following questions. Thank you.

**If you choose not to participate please initial here: _____

RACE
- ☐ American Indian/ Alaskan Native
- ☐ Native Hawaiian
- ☐ Asian
- ☐ African American/ Black
- ☐ Caucasian / White

ETHNICITY
- ☐ Hispanic / Latino
- ☐ Not Hispanic or Latino
- ☐ Other: _____

PREFERRED LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Do you have a living will or other advanced directive? ☐ YES ☐ NO

INSURANCE INFORMATION

Do you have Medicare: ☐ YES ☐ NO ☐ Primary ☐ Secondary
Do you have Medicaid: ☐ YES ☐ NO ☐ Primary ☐ Secondary

Primary Insurance Company: _____

Address: _____City: _____ State: _____ Zip: _____
Members Insurance ID#: _____ Group #: _____
Name of Insured if other than patient: _____
Relationship to Patient: _____
Insured DOB: _____ SS#: _____

Secondary Insurance Company: _____

Address: _____City: _____ State: _____ Zip: _____
Members Insurance ID#: _____ Group #: _____
Name of Insured if other than patient: _____
Relationship to Patient: _____
Insured DOB: _____ SS#: _____

How did you hear about our practice? _____

Print Name: _____

Patient Signature: _____Date_____

THERE WILL BE A $25.00 CHARGE FOR ALL INSURANCE /FMLA /DISABILITY PAPERWORK, AND HAVE 20 WORKING DAYS TO COMPLETE. MEDICAL RECORDS WILL HAVE A $25 FLAT FEE FOR ALL RECORDS RELEASE TO PATIENTS UPON SIGNING A RELEASE AND NO LONGER WITH AHV OFFICE.

MEDICAL HISTORY

PLEASE CHECK TO THE RIGHT OF EACH ITEM	YES	NO	DON'T KNOW	PLEASE CHECK TO THE RIGHT OF EACH ITEM	YES	NO	DON'T KNOW
Asthma *J45.909*				HIV *Z21*			
Aneurysm *Z86.79*				Irregular Heartbeat *I49.9*			
Angina *120.9*				Kidney Artery Angio/Stent *Z95.828*			
Shortness of Breath *R06.02*				Kidney Failure *N19*			
Artery Clot *V12.59*				Kidney Stone *N20.9*			
AFIB *148.91*				Leg or Arm Angioplasty/ Stent *Z98.89*			
Aflutter *148.92*				Leg *I82.402 /I821* Arm Clots *I82.609*			
Blood or Clotting disorder *V12.3*				Liver *K76.9*			
Arm clots *I82.609*				Narcolepsy *G47.419*			
Bronchitis *J40* Emphysema *J43.9*				Peptic Ulcer *K27.9*			
Hypertension *I10*				P.V.D. *I73.9*			
Cancer Type _____ *V10.9*				Prostate *N42.9*			
Carotid Stent *V43.4*				Rheumatic *N42.9*			
Chest Pain *R07.9*				Seizures *G40.909*			
CHF *I50.9*				Sleep Apnea *G47.30*			
CAD *I25.10*				Stomach Artery Angio/Stent *Z95.828*			
Diabetes How long? _____ *E11.9*				Thyroid Disease *E07.9*			
Gallbladder *K82.9*				Stroke *I63.9*			
Heart Attack (MI) *I21.3*				CVA *I67.89*			
Hemodialysis *Z99.1*				Valvular Heart Disease *I35.9*			
Hepatitis *K75.9*				High Cholesterol *E83.9*			

ALLERGIES

Do you have allergies to drugs, food, latex, dye? ☐ YES ☐ NO

ALLERGY – LIST MEDICATION, FOOD, LATEX, DYE, ETC.	REACTION – RASH, SHORT OF BREATH, HIVES, ITCHING, ETC.

SOCIAL HISTORY AND LIFESTYLE

Alcohol use	☐ Yes	☐ No	☐ Beer ☐ Wine ☐ Liquor
Smoking/Tobacco Use 305.1	☐ Yes	☐ No	Number of years ____ Packs smoked per day ____
Profession	☐ Working	☐ Retired	☐ Unemployed
Marital Status	☐ Married	☐ Single	☐ Divorced/Separated
Living Status	☐ Spouse	☐ Alone	☐ Other: _____
Diet	☐ Yes	☐ No	☐ Type: _____
Caffeinated Beverages	☐ Yes	☐ No	days per week: _____ How long? _____
Substance Abuse	☐ Yes	☐ No	Drug Dependency?
Military	☐ Yes	☐ No	Branch?

CURRENT MEDICATIONS

List all vitamins, prescription medications, and over-the-counter medications
Bring ALL medications in their original containers to every appointment

MEDICATION NAME	DOSAGE	HOW OFTEN DO YOU TAKE?	PRESCRIBING PHYSICIAN

PAST SURGERIES & PROCEDURES

Past Surgeries/Procedures	YES	NO	DON'T KNOW	Past Surgeries/Procedures	YES	NO	DON'T KNOW
Ankle *Z96.669*				AICD/ DEFIB *Z95.810*			
Appendectomy *Z90.49*				Aortic Aneurysm Repair *Z98.89*			
Back *Z90.10*				Cardiac Cath *Z98.89*			
Breast *Z98.49*				Cardioversion *Z98.89*			
Cataract *Z98.49*				Coronary Angioplasty *Z98.61*			
Gallbladder *Z90.89*				Cardiomyoplasty			
Gastric Bypass *V45.86*				Coronary Artery Bypass *Z95.1*			

Past Surgeries/Procedures	YES	NO	DON'T KNOW	Past Surgeries/Procedures	YES	NO	DON'T KNOW
Hernia *Z91.49*				Coronary Revascularization *Z95.1*			
Hip *Z96.49*				EP Study			
Hysterectomy *Z90.79*				Heart Transplant			
Intestinal *Z90.49*				Heart Valve Surgery *Z94.1*			
Knee *Z96.659*				Homograft Replacement *Z95.4*			
Lap Band *Z98.84*				Valvuloplasty *Z98.89*			
Prostate *Z98.84*				ICD Lead Extraction *T827XXA*			
Sleep Apnea Surgery *V90.89*				Pacemaker Implant *Z95.0*			
Tonsils *Z90.89* Adenoids *Z90.89*				RF Ablation *Z98.89*			

Any Family History of Cancer, Diabetes, High Blood Pressure, Heart Disease, Heart Attack, etc.?

Please list any: _____

_____

_____

_____

**Our cardiovascular specialists have privileges at Baptist Medical Centers, Baptist South, Memorial Hospital Jacksonville, Orange Park Medical Center, Specialty Hospital, Brooks Rehabilitation Hospital, St. Vincent's Medical Center Southside and Flagler Hospital. If you or your family members are admitted to these hospitals, please ask the your nurse or administration for your doctor here at Ashchi Heart & Vascular Center so we may provide you with the continuous excellent care you always enjoyed with our group. We are on call for our patients 24/7 at these locations. Our group provides you with board-certified cardiologists and vascular specialists in several First Coast area locations.

Print Name: _____

Signature: _____

Date: _____

Peripheral Vascular Disease (PVD) is a common circulatory problem in which vessels carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PVD.

Please check "Yes" or "No" on the following questions and check all boxes that apply:

1. Have you been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? ☐ YES ☐ NO

2. If you have pain, does the pain subside with rest? ☐ YES ☐ NO

3. Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms? ☐ YES ☐ NO
If yes, dates: _____

4. Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed?
☐ YES ☐ NO

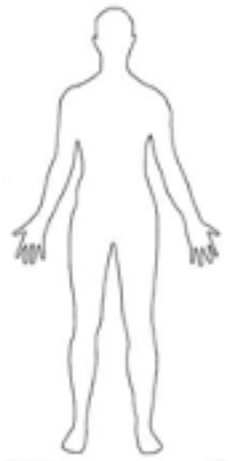
5. When you walk, do you experience aching, cramping, or pain in your arms, legs, thighs, or buttocks? ☐ YES ☐ NO

6. Do you have any painful sores or ulcers on legs or feet that do not heal? ☐ YES ☐ NO

7. If you answered **Yes** to #5, when do you feel the pain:
☐ After walking 1 block
☐ Climbing a flight of stairs
☐ After walking 100 yards
☐ Walking at increased speed

8. Are your legs or arms pale, discolored, or bluish? ☐ YES ☐ NO

9. If you answered **Yes** to #5, circle the area(s) of the body on the diagram below where you feel pain.



10. Check all that apply:

☐ I am a current smoker
☐ I have a history of smoking
☐ I have diabetes
☐ I have a family history of diabetes
☐ I have high cholesterol
☐ I have a family history of high cholesterol
☐ I have high blood pressure/hypertension
☐ I have a family history of high blood pressure/hypertension
☐ I have coronary artery disease (CAD)
☐ I have a family history of coronary artery disease
☐ I have had a stroke/mini-stroke/TIA
☐ I have a family history of stroke/mini- stroke/TIA

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EPWORTH SLEEPINESS SCALE

Date: _____

Patient: _____ DOB: _____

Are you currently using a CPAP? ☐ YES ☐ NO Do You have Sleep Apnea? ☐ YES ☐ NO

Rate your sleepiness as: 0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

How likely are you to doze off or fall asleep in the following situations? Use the sleepiness scale to choose the appropriate number for each situation.

1.	Sitting and reading	_____
2.	Watching TV	_____
3.	Lying down to rest in the afternoon	_____
4.	Sitting inactive in a public place (watching movie, in a meeting)	_____
5.	As a passenger in a car for an hour without a break	_____
6.	Sitting and talking to someone	_____
7.	Sitting quietly after lunch without alcohol	_____
8.	In a car, while stopped for a few minutes in traffic	_____

TOTAL (SUM OF NUMBERS ABOVE) **Total:** _____

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SLEEP QUESTIONAIRE

Name: _____ DOB: _____

Please check **ALL** that apply to you:

- ☐ Do you snore?
- ☐ Have you been told that you stop breathing during sleep?
- ☐ Do you wake up gasping for breath?
- ☐ Have you been told you often kick and mover your legs during sleep?
- ☐ Are you excessively tired during the day?
- ☐ Do you have a history of hypertension (high blood pressure)?
- ☐ Do you feel tired even when you thought you had a good night of sleep?
- ☐ Have you been diagnosed with atrial fibrillation or congestive heart failure?
- ☐ Is your neck size greater than 17 inches (male) or greater than 16 inches (female)?
- ☐ Do you awaken unrefreshed?
- ☐ Do you have a sensation of crawling feelings or discomfort in your legs when trying to sleep?
- ☐ Do you have trouble with falling asleep at night?
- ☐ Have you been told you talk or walk in your sleep?
- ☐ Do you suffer from occasional bedwetting?
- ☐ Have you been told that you act our your dreams?
- ☐ Do your feel paralyzed when falling asleep or waking up?
- ☐ Do your experience sudden weakness when laughing?
- ☐ Do you regularly require long naps during the day?
- ☐ Do you have uncontrollable daytime sleep attacks?
- ☐ Do you find yourself falling asleep during work or school?
- ☐ Have you noticed difficulty concentrating during the day?
- ☐ Do you find yourself falling asleep while driving?
- ☐ Have you notice behavioral difficulties or difficulties at school?
- ☐ Do you suffer from teeth grinding during sleep?

1. Have you had a sleep study before? ☐ YES ☐ NO

If yes, When? _____ Where? _____ Doctor's name? _____

2. Have you had a sleep study and CPAP before? ☐ YES ☐ NO

If yes, When? _____ Where? _____ Doctor's name? _____

3. Bed Partner? ☐ YES ☐ NO If yes, Who? _____

4. How many hours do you sleep a night? _____

Sleep meds or AID? ☐ YES ☐ NO Type: _____ How long? _____

5. Alcohol use? ☐ YES ☐ NO How much? _____ What type? _____

If yes, Do you use it to sleep? ☐ YES ☐ NO

6. Do you use caffeine? ☐ YES ☐ NO How much?_____ What type? _____

How long have you been using caffeine? _____

7. Naps? ☐ YES ☐ NO Duration? _____ Describe: _____

8. Sleepy while driving? ☐ YES ☐ NO ☐ MVA or Occupational accident due to sleepiness?

Describe:_____

9. Insomnia? ☐ YES ☐ NO Describe:_____

10. SDB symptoms? ☐ Dry Mouth ☐ Frequent arousal ☐ Choking/gasping ☐ Witnessed apnea
☐ Sore Throat ☐ Morning Headache ☐ Unrefreshed in AM ☐ Snoring

Describe:_____

11. Restless Leg Syndrome symptoms? ☐ YES ☐ NO

Explain: _____

Charlie Horses? ☐ YES ☐ NO Describe: _____

12. Narcolepsy symptoms? ☐ Cataplexy ☐ Sleep Paralysis ☐ Hallucinatory imagery
Describe: _____

13. RBD symptoms? ☐ Dream enactment ☐ Sleep Injuries
Describe: _____

14. Other symptoms? ☐ Parasomnia ☐ Sleep talking ☐ Groaning
Describe: _____