Clear Lake Heart & Vein Center
Phone: (281) 338-2098 Fax: (281) 557-4369

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Date of Birth:
Social Security No:		Marital Status:	S M W D
Address:		City, ST, Zip:	
Home Ph:	Cell Ph:	Work Ph:	
Employer:		Email:	

EMERGENCY CONTACT

Name of person to notify in case of emergency:	
Home Ph:	Cell Ph:
Relationship:	

SPOUSE INFORMATION

Name of Spouse:	Day Time Ph:
Social Security No:	Date of Birth:
Employer:	

PRIMARY INSURANCE INFORMATION

Insurance Co:	Group Name:
Policyholder Name:	Group #:
Member ID#:	
REFERRAL REQUIRED?	

SECONDARY INSURANCE INFORMATION

Insurance Co:	Group Name:
Policyholder Name:	Group #:
Member ID#:	

REFERRAL INFORMATION

Referring Physician:	Office Phone:
Primary Care Physician:	Office Phone:

We will bill your primary and secondary insurance company, however all unpaid charges over 60 days old will be considered the patient's responsibility. If a referral from your Primary Care Physician is required, it is your responsibility to obtain the referral prior to your visit and/or testing. **Unauthorized care is the responsibility of the patient.**

I have read and agree to the terms stated above. I authorize payment of medical benefits to be paid directly to Harvey E. Slusky M.D., PA for professional services rendered. I also authorize the release of any medical information and/or records which may be necessary to process my charges. In addition, I understand that this authorization and acknowledgement is to remain in effect until revoked by me in writing.

Patient's Signature:____ **Date:**____________________

PLEASE PROVIDE INSURANCE CARDS AND DRIVER'S LICENSE FOR COPYING

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REVIEW OF SYSTEMS

PATIENT NAME:______________________________ DOB:__________

PRIMARY CARE PHYSICIAN:______________________________

REFERRING PHYSICIAN:______________________________

PHARMACY NAME:______________________________

PHARMACY PHONE/ADDRESS:______________________________

PREFERRED LANGUAGE:__________________ RACE:__________________

ETHNICITY (CIRCLE ONE): HISPANIC OR LATINO NON-HISPANICT LATINO OTHER OR UNDETERMINED

Please check as many of the following symptoms that you have experienced

- o anxiety
- o asthma
- o blood in stool
- o blood in urine
- o chest heaviness
- o chest pain
- o chest tightness
- o cough
- o depression
- o dizziness
- o edema / leg swelling
- o erectile dysfunction
- o fatigue or weakness
- o high blood pressure
- o high cholesterol
- o joint pain
- o leg pain with walking / exercising
- o lightheadedness
- o muscle pain or weakness
- o numbness / tingling in extremities
- o pain between shoulder blades / in jaw or arms with exertion or exercise
- o palpitations
- o shortness of breath
- o shortness of breath while lying down
- o significant weight change
- o skin rash
- o sleep disorder / apnea
- o stomach pain after eating

o **DENY ALL OF THE ABOVE**

LAST FLU VACCINE: month/year _______ LAST PNEUMONIA VACCINE: month/year _________

	YES	NO	
HOSPITALIZATIONS?	o	o	**When & why?:** ______________________
New illness or diagnosis?	o	o	Name of illness / diagnosis: ______________________
New Lab or diagnostic test?	o	o	Name of lab / test: ______________________
Change in family history?	o	o	Explain: ______________________

CURRENT MEDICATIONS (If you have a list, we can make a make a copy for you)

Patients Signature: ______________________________ Date: ______________

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MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: ______________________ **DATE:** __________ **DOB:** __________

FAMILY MEDICAL HISTORY:

	Father	Mother	Sister 1	Sister 2	Brother 1	Brother 2
Diabetes						
Heart Attack (Age <65)						
High Blood Pressure						
Living						
Stroke/CVA (Age <65)						

ALLERGIES:

	Yes	No
Are you allergic to iodine or shellfish?	☐	☐
Have you had a reaction to x-ray contrast dye?	☐	☐
Are you allergic to any medications?	☐	☐

(If yes, please list medication names): ______________________

PAST MEDICAL HISTORY:

- Abnormal Heart Rhythm
- Anemia or Blood Disorder
- Anxiety
- Asthma
- Arthritis
- Atrial Fibrillation
- Blood Clots veins/lungs
- Cancer
- COPD/Emphysema
- Diabetes
- Easy bruising/bleeding
- Heart Attack
- Heart Murmur
- Hepatitis
- High Blood Pressure
- High Cholesterol
- High Triglycerides
- HIV/AIDS
- Kidney Disorder
- Liver Problems
- Seizures
- Sleep Apnea
- Stroke or TIA
- Thyroid Disorder
- Tuberculosis
- Valvular Heart Disease
- Varicose Veins

NON-CARDIAC PAST SURGICAL HISTORY:

____

____

CARDIOVASCULAR TESTING & SURGICAL HISTORY:

- Cardiac Echocardiogram
- Nuclear Testing
- Vascular Testing
- Holter Monitor or Event Monitor
- Electrophysiology Study
- Pacemaker/ICD
- Bypass Surgery
- Heart Catheterization
- Coronary Angioplasty (balloon)/Stents
- Valve repair or replacement
- Stress Test
- Heart Transplant

SOCIAL HISTORY:

TOBACCO USE: Currently smoke? __________ packs per day for ________ years
Previous smoker for __________ years. Date/Year quit: ______________

ALCOHOL USE: ☐ Yes ☐ NoIf yes, how many drinks per day? ___ Type? __________

CAFFEINE: ☐ Yes ☐ No If yes, how many caffeinated drinks per day? __________

DRUG USE: Have you ever used illicit drugs? ☐ Yes ☐ No If yes, year started/stopped _____ Type? _______

PARTICULAR DIET: ☐ Yes ☐ No If so, please describe __________

EXERCISE: ☐ Yes ☐ No If yes, what type? __________ How often? __________