The Heart Health Centre

EDUCATION • PREVENTION
INTERVENTION
SUPPORT & MANAGEMENT

The Heart Health Centre

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NEW PATIENT INSTRUCTIONS

In order to help us serve you, and all our clients optimally, please:

- **Complete new patient forms and insurance information prior to your appointment date.** If you have questions regarding the forms, please call and speak to one of our staff members 48 hours prior to your appointment. We're happy to help.

- **Make sure we have a current phone number and that you have space on your voicemail to receive messages. If you receive a voicemail message from us, please return the call to confirm receipt.** It is our policy to call and confirm appointments ahead of time. We also provide a courtesy reminder the day prior to your appointment. If we are unable to reach you, your appointment spot may be given to someone else who is waiting to be seen.

- **Bring your completed forms (if not returned prior),** one form of photo identification, and your insurance card with you to your appointment.

- **Bring all current medications with you**.

- **Arrive 15 minutes prior to your appointment time.** We strive to run on schedule, however sometimes despite our best efforts we do run behind schedule. If we are running extremely behind schedule we may call and ask you to arrive at a later time so that you do not have to wait a long time in the office.

- **New paitent (initial) appointments last about one hour.**

Please note: Patients who arrive **15 minutes after their scheduled appointment** time will be rescheduled in the next available appointment slot.

If you cannot make your scheduled appointment, we appreciate you letting us know as soon as possible (preferably with at least 24 hours notice). This gives other patients needing to see the cariologist an opportunity to receive an appointment time.

Thank You

Date: _____ Physician:_____ Staff Initials _____

Health History

Patient to Complete

Name_____
Address/PO Box _____
District:_____
Phone (H) _____(W)_____
(C) _____ (O) _____
Email _____ Age_____
Date of Birth (DD/MM/YY) _____

Reason for visit _____
_____
_____
Famly/Referring Physician_____
_____
Date of last visit to Heart Health Centre
_____

Cardiovascular Review

Chest discomfort	Yes ❑	No ❑
Shortness of breath	Yes ❑	No ❑
Skipped heart beats	Yes ❑	No ❑
Fainting or passing out	Yes ❑	No ❑
Awaken gasping for air	Yes ❑	No ❑
Difficulty breating while lying down	Yes ❑	No ❑
Swelling of ankles/legs	Yes ❑	No ❑
Lighteaded	Yes ❑	No ❑
Irregular or fast rhythm	Yes ❑	No ❑
Leg pain while wallking	Yes ❑	No ❑

OTHER:_____
_____

Drug Allergies

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medications

Name	Dose (mg)	Frequency	Name	Dose (mg)	Frequency
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

OFFICE USE ONLY - Chief complaint (HPI) DO NOT WRITE

Vital Signs

Blood Pressure:
Right _____
Left_____

Pulse:_____
Temp:_____
Resp: _____

Height: _____
Weight: _____
Prev. Weight: _____

Patient to Complete

Risk Factors

Yes No

- ❑ ❑ Do you have a history of high blood pressure?
- ❑ ❑ Is there a family history of heart attack?
- ❑ ❑ Do you smoke or use tobacco?
- ❑ ❑ Have you smoked in the past?
- ❑ ❑ If yes, how much and how long?

  Date Quit: _____
- ❑ ❑ Do you have a history of high cholesterol?
- ❑ ❑ Most recent profile date

  TC _____ HDL _____ TC/HDL _____

  Trig _____ LDL _____
- ❑ ❑ Are you diabetic?

  If yes, are you on insulin? Yes ❑ No ❑

  On oral medication? Yes ❑ No ❑

  Average Blood Sugar? _____
- ❑ ❑ Are you post menopausal?
- ❑ ❑ Have you had a hysterectomy?
- ❑ ❑ Are you on Estrogen?
- ❑ ❑ Is there a family history of breast cancer?
- ❑ ❑ Have you had breast cancer?

Social History

Marital Status:

❑ Single ❑ Married ❑ Widowed

❑ Separated ❑ Divorced

Occupation: _____

Yes No

- ❑ ❑ Do you live by yourself?
- ❑ ❑ Do you have any children?
- ❑ ❑ If yes, how many and ages?
- ❑ ❑ Caffeine use: How much? _____
- ❑ ❑ Alcohol Use? If yes, how much _____ oz.

  ❑ Daily ❑ Weekly ❑ Monthly
- ❑ ❑ Illicit drug use?
- ❑ ❑ Do you follow a low fat diet?
- ❑ ❑ Do you follow a low salt diet?
- ❑ ❑ Do you exercise?

If yes, what type and how often? _____

_____

Family History

	Living Age	Deseased Age	Health Problems/Cause
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

1. Does your heart condition interfere with your ability to perform physical activities?

   ❑ Never ❑ Rarely ❑ Occassionally ❑ Often ❑ Always

2. Does your heart condition affect your emotional well-being?

   ❑ Never ❑ Rarely ❑ Occassionally ❑ Often ❑ Always

3. Overall, are you satisfied with the current treatment of your heart disease?

   ❑ Yes ❑ No

4. If you had to spend the rest of your life with your current symptoms, how would you feel about it?

   ❑ Dissatisfied ❑ Somewhat Satisfied ❑ Satisfied

Symptom Review

Date: _____ Name:_____ Chart #: _____

Patient to Complete

Please put a check mark by the following signs or symptoms you have experienced in the last year.
(boxes left empty indicte absence of symptom)

Constitutional Review
- ❑ Fevers
- ❑ Night sweats
- ❑ Unexplained weight loss/gain (>7-10 pounds)
- ❑ Easily fatigued

Ears, Nose & Throat Review
- ❑ Hearing loss (not corrected by hearing aids)
- ❑ Hoarseness
- ❑ Sore throat
- ❑ Sinus congestion
- ❑ Difficulty swallowing

Eyes
- ❑ Eye trouble (not corrected by glasses)
- ❑ Blurred vision
- ❑ Double vision
- ❑ Last eye exam _____

Pulmonary
- ❑ Cough
- ❑ Difficulty breathing flat
- ❑ Difficulty with breathing at night
- ❑ Wheezing
- ❑ Snore
- ❑ Daytime drowsiness
- ❑ Restless sleeper
- ❑ I stop breathing at night
- ❑ I wake up in the morning tired and unrefreshed

GI Review
- ❑ Indigestion or heartburn
- ❑ Change in bowel habits or stool color
- ❑ Black stools or bleeding from the bowels
- ❑ Nausea/vomiting
- ❑ Trouble swallowing
- ❑ Last colon exam _____

GU Review
- ❑ Frequent bladder infections
- ❑ Painful urination
- ❑ Frequent urination
- ❑ Sexual difficulties
- ❑ Blood in the urine
- ❑ Night-time urination
- ❑ Last PSA _____
- ❑ Loss of bladder control

GYN Review
- ❑ Post menopausal
- ❑ Estrogen replacement therapy
- ❑ Last Pap _____
- ❑ Last mammogram _____
- ❑ I am or could be pregnant now

Neurological Review
- ❑ Paralysis
- ❑ Temporary loss of speech or slurred speech
- ❑ Temporary loss of vision
- ❑ Numbness/weakness of hands, legs or feet
- ❑ Trouble with balance
- ❑ Headaches
- ❑ Seizures
- ❑ Dizziness

Musculoskeletal
- ❑ Muscular aching
- ❑ Join pain

Endocrine Review
- ❑ Exessive thirst
- ❑ Skin moistness or dryness
- ❑ Heat intolerance
- ❑ Cold intolerance

Skin Review
- ❑ Skin rash
- ❑ Itching

Hematopoletic/Lymphatic Review
- ❑ Swollen glands
- ❑ Bleed easily
- ❑ Bruising easily
- ❑ Anemia (low blood count)
- ❑ Nose bleeds

Psychosocial/Social
- ❑ Sleeplessness
- ❑ Sleeping more than usual
- ❑ Loss of appetite
- ❑ Feeling depressed
- ❑ Anxiety
- ❑ Agitation
- ❑ Increased stress/trouble at work or home

Past Medical / Surgical History

Patient to Complete

List all surgeries:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List all chronic health issues:

_____

_____

_____

_____

_____

_____

_____

For Office Use Only

NOTES:

Insurance Information

Patient to Complete

Patient Name_____
Last *First* *Middle Initial*

Patient's Post Office Box_____ Postal Code_____District_____

Patient's Date of Birth (MM/DD/YY) _____

Patient's Relationship to insured _____ (self, spouse, child)

Telephone (home) _____ (cell) _____

Insurance Company Name _____

Insured's ID or Certificate Number _____

Insured's Policy, Group or FECA Number _____

Insured's Employer or School:_____

Insured's Name: _____
Last *First* *Middle Initial*

Insured's Date of birth (MM/DD/YY) _____

Insured's Post Office Box _____ Postal Code_____District_____