



**Cardiothoracic and Vascular Surgeons**  
**1010 W. 40<sup>th</sup> St., Austin, TX 78756**  
**Tel: (512) 459-8753 Fax: (512) 459-0586**

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**HISTORY AND PHYSICAL CONSULTATION FORM**

**Date:** \_\_\_\_\_ **Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Sex:** M / F (*circle one*) **Ht:** \_\_\_\_\_ **ft:** \_\_\_\_\_ **in** **Wt:** \_\_\_\_\_ **lbs** **BP:** \_\_\_\_\_ / \_\_\_\_\_ **Pulse:** \_\_\_\_\_ **bpm**

**Reason for today's visit:** \_\_\_\_\_

**Medication ALLERGIES:** OR  **NONE** (*no allergies*)

<b>Medication</b>	<b>Reaction you have</b>
1. _____	_____
2. _____	_____
3. _____	_____

**MEDICATIONS you currently take:** OR  **NONE** (*check box if you take no meds*)

<b>Medication</b>	<b>Dose</b>	<b>How often</b>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

**PAST MEDICAL HISTORY:** (CIRCLE THE CONDITIONS BELOW THAT APPLY TO YOU)

<b>Aneurysm:</b> abdominal, thoracic (chest), cerebral (brain), peripheral (legs)	<b>Genitourinary Disease:</b> urinary frequency, incontinence, prostate problems
<b>Autoimmune Disorder:</b> lupus, MS, rheumatic fever, Sjogren's syndrome	<b>Heart Valve Disease:</b> aortic, mitral, tricuspid
<b>Blood Thinners:</b> Coumadin, Plavix, Aspirin, Xarelto, Pradaxa, Fish Oil	<b>Hematologic Disease:</b> anemia, clotting disorder, bleeding disorder
<b>Cancer:</b> what type? _____	<b>Hyperlidemia</b> (high cholesterol)
<b>Cardiac Arrhythmias:</b> A-fib, PVC	<b>Hypertension</b> (high blood pressure)
<b>Carotid Stenosis</b>	<b>Kidney Disease:</b> renal cysts, renal transplant
<b>Congenital Heart Disease:</b> ASD, VSD, AVSD, Marfan's, bicuspid valve	<b>Liver Disease:</b> jaundice, hepatitis, cirrhosis
<b>Coronary Artery Disease:</b> heart attack (MI), chest pain	<b>Musculoskeletal:</b> arthritis, osteoporosis, back pain
<b>Dermatology:</b> shingles, psoriasis	<b>Neurologic Disorder:</b> schizophrenia, bipolar disorder, epilepsy
<b>Diabetes:</b> Type 1 Insulin-Dependent, Type 2 Non-Insulin Dependent	<b>Pacemaker</b>
<b>ENT:</b> Ears, Nose, Throat problems	<b>Peripheral Vascular Disease:</b> DVT, claudication
<b>End Stage Renal Disease</b> (kidney failure)	<b>Pulmonary/Respiratory Disease:</b> asthma, COPD, TB
<b>Endocrine problems:</b> thyroid- high / low, parathyroid- high / low, adrenal gland, pituitary	<b>Sleep Disorder:</b> insomnia, sleep apnea, narcoleps
<b>Eye Problems:</b> glasses, cataracts, glaucoma, etc	<b>Other #1:</b> _____
<b>Gastrointestinal Disease:</b> ulcers, Crohn's, diverticulitis, gallstones, IBS, reflux/heartburn	<b>Other #2:</b> _____

**SURGICAL HISTORY:** (Please list all prior surgeries and dates)

DATE	SURGERY

**SOCIAL HISTORY:**

**Smoking Status:**

Never smoked     Former smoker     Current smoker *daily*     Current smoker *occasionally*

Number of years you have used tobacco (**even if you quit**): \_\_\_\_\_

How much do you (or did you) smoke?  1 pack per day     2 packs per day     1 pack per week     Other: \_\_\_\_\_

**Alcohol Intake:**     None     Occasional     Moderate     Heavy

**Illicit Drugs:**     None     Yes: (what and how often?) \_\_\_\_\_

**Exercise Level:**     None     Occasional     Moderate     Heavy

**Marital Status:**     Married     Single     Divorced     Widowed     Domestic Partner

**FAMILY MEDICAL HISTORY:**    OR     None/Unknown

	Mother ✓	Father ✓	Sister ✓	Brother ✓
Aneurysm				
Heart Attack (MI)				
Bleeding				
Blood Clots (DVT)				
Cancer (List type of Cancer)				
Congenital Heart Disease				
Diabetes				
Heart Failure				
Hypertension				
Hyperlipidemia				
Kidney Failure				
Obesity				
Rheumatic Fever				
Stroke				

**PROVIDERS:**

- Pharmacy / Location: \_\_\_\_\_

- Primary Care Doctor or Clinic / Phone #: \_\_\_\_\_

- Referring Doctor / Phone #: \_\_\_\_\_

- Other Doctors (*pulmonologist, oncologist, cardiologist, etc.*) / Phone #: \_\_\_\_\_

\_\_\_\_\_  
Dialysis Unit / Days you dialyze (*if applicable*): \_\_\_\_\_

## Cardiothoracic and Vascular Surgeons - Review Of Systems (ROS)

*(please check all the following conditions listed below that you are currently experiencing. If applicable, provide additional notes about the condition)*

Patient Name \_\_\_\_\_ Patient D.O.B. \_\_\_\_\_ Date \_\_\_\_\_ Athena # \_\_\_\_\_  
(for staff only)

<b><u>Constitutional</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> significant weight gain <input type="checkbox"/> significant weight loss <input type="checkbox"/> exercise intolerance <input type="checkbox"/> fatigue Comments _____
<b><u>Eyes</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> dry eyes <input type="checkbox"/> eye irritation <input type="checkbox"/> vision changes <input type="checkbox"/> difficulty reading: needs glasses/contacts Comments _____
<b><u>Ears</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> difficulty hearing <input type="checkbox"/> ear pain Comments _____
<b><u>Nose</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> frequent nosebleeds <input type="checkbox"/> nose/sinus problems Comments _____
<b><u>Mouth/Throat</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> sore throat <input type="checkbox"/> bleeding gums <input type="checkbox"/> snoring <input type="checkbox"/> dry mouth <input type="checkbox"/> mouth ulcers <input type="checkbox"/> oral abnormalities <input type="checkbox"/> teeth problems Comments _____
<b><u>Cardiovascular</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> chest pain <input type="checkbox"/> chest pain on exertion <input type="checkbox"/> shortness of breath when walking <input type="checkbox"/> shortness of breath when lying down <input type="checkbox"/> palpitations <input type="checkbox"/> known heart murmur <input type="checkbox"/> lightheadedness Comments _____
<b><u>Respiratory</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath <input type="checkbox"/> coughing up blood <input type="checkbox"/> sleep disturbances (sleep apnea) Comments _____
<b><u>Gastrointestinal</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> abdominal pain <input type="checkbox"/> vomiting <input type="checkbox"/> abnormal appetite <input type="checkbox"/> diarrhea <input type="checkbox"/> vomiting blood <input type="checkbox"/> black or tarry stools Comments _____
<b><u>Genitourinary</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> incontinence (loss of urinary control) <input type="checkbox"/> difficulty urinating <input type="checkbox"/> increased urinary frequency <input type="checkbox"/> hematuria <input type="checkbox"/> change in urinary output <input type="checkbox"/> incomplete emptying of bladder Comments _____
<b><u>Musculoskeletal</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> muscle aches <input type="checkbox"/> muscle weakness <input type="checkbox"/> arthralgias/joint pain <input type="checkbox"/> back pain <input type="checkbox"/> swelling in the extremities <input type="checkbox"/> needs wheelchair <input type="checkbox"/> needs walker Comments _____
<b><u>Neurologic</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> loss of consciousness <input type="checkbox"/> weakness <input type="checkbox"/> numbness <input type="checkbox"/> seizures <input type="checkbox"/> dizziness <input type="checkbox"/> frequent/severe headaches <input type="checkbox"/> migraines <input type="checkbox"/> restless legs Comments _____
<b><u>Hematologic/ Lymphatic</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> swollen glands <input type="checkbox"/> bruising <input type="checkbox"/> easy / excessive bleeding tendency Comments _____
<b><u>Allergic/ Immunologic</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> runny nose <input type="checkbox"/> sinus pressure <input type="checkbox"/> itching <input type="checkbox"/> hives <input type="checkbox"/> frequent sneezing Comments _____
<b><u>Endocrine</u></b>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> excessive thirst or water consumption <input type="checkbox"/> overall weakness <input type="checkbox"/> excessive facial or body hair growth <input type="checkbox"/> temperature intolerance Comments _____
<b><u>Lung Symptoms</u></b>  <i>Check the lung symptoms that you are currently having had.</i>	<input type="checkbox"/> <b>NONE</b> or: <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Enlarged Lymph Nodes <input type="checkbox"/> Chronic pulmonary heart disease (enlarged heart area from pumping/working harder) <input type="checkbox"/> Atherosclerosis of aorta (plaque build up in major heart artery) <input type="checkbox"/> Mucopurulent (yellow/green mucus) Chronic Bronchitis <input type="checkbox"/> Chronic Airway Obstruction (airways often congested/tight feeling) <input type="checkbox"/> Hemoptysis (coughing up blood/bloody sputum) <input type="checkbox"/> Other Chest Pain <input type="checkbox"/> Tachypnea (very rapid breathing) <input type="checkbox"/> Swelling mass/lump-Chest <input type="checkbox"/> Abnormal Chest Sounds (popping, rattling, crackling chest sounds) <input type="checkbox"/> Abnormal Electrocardiogram (EKG) Comments _____



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## **CTVS General Consent Form to the Use and Disclosure of Protected Health Information**

I understand that **Cardiothoracic and Vascular Surgeons** creates and maintains medical and related records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is my “protected health information”.

I understand and consent to the use and disclosure of my Health Information by Cardiothoracic and Vascular Surgeons for the following purposes:

- My treatment: This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional and participation in SureScripts Pharmacy database.
- Payment for healthcare services provided to me: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.
- My Provider's internal operations: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.
- My personal release: I authorize the release of my protected health information to myself at any time.
- Use of my mobile number: I authorize automated messages and alerts to me from this practice.

I understand and agree that:

- I have the right to review Cardiothoracic and Vascular Surgeons *Notice of Privacy Practices for Protected Health Information*, which provides a much more detailed description of information uses and disclosures, prior to signing this Consent.
- **Cardiothoracic and Vascular Surgeons** may change or modify its *Notice of Privacy Practices for Protected Health Information* at any time and I have the right to obtain a revised notice of privacy practices by accessing the Cardiothoracic and Vascular Surgeon's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.
- I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my Provider is not required to agree to any restrictions that I may request, but if my Provider agrees, it will be bound by that restriction.
- I have the right to revoke this Consent by notifying my Provider *in writing* that I revoke this Consent unless my Provider has used or disclosed my Health Information in reliance on this Consent.
- My Provider has the right to disclose relevant Health Information to my family member, other relative, close personal friend, or anyone identified by me.



## **CTVS General Consent Form to the Use and Disclosure of Protected Health Information**

<b>Signature of Patient</b>	
<b>Printed Name of Patient</b>	
<b>Date</b>	<b>Email</b>
<b>Guardian or responsible party signature</b>	<b>Relationship to Patient</b>

**I hereby authorize the release of my protected health information to the following individuals:**

Name	Relationship	Email or Phone
Name	Relationship	Email or Phone
Name	Relationship	Email or Phone
Name	Relationship	Email or Phone
Name	Relationship	Email or Phone



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## **FINANCIAL RESPONSIBILITY**

I understand that on ALL services billed to my insurance company there may be an additional balance due. This is determined by my insurance company's benefit plan. This includes co-pays and deductibles.

I understand that if my insurance denies the claim(s) for medical necessity, out of network, not a covered benefit, plan terminated, is considered experimental or investigational by my plan, etc. that I will be financially responsible for the payment of the services according to the protocol of this office.

I understand if I am admitted to the hospital there may be other charges for medical services that may be considered out of network with my insurance company for which I may be responsible. CTVS cannot control or guarantee that only in-network providers for your insurance plan will be utilized by the hospital in which you receive treatment.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Email or Phone**

\_\_\_\_\_  
**Guardian or Responsible Party Signature**

\_\_\_\_\_  
**Relationship to Patient**

# Dear Patients,

Your medical provider is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients.

As part of this program, the government requires us to record the following demographic information about you:

- ▶ Preferred language    ▶ Race    ▶ Ethnicity    ▶ Date of birth    ▶ Gender

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential.

You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

## Cardiothoracic and Vascular Surgeons

### Please identify your Race from the following CDC-defined options:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> African                          | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Japanese                                  | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> African American                 | <input type="checkbox"/> American                  | <input type="checkbox"/> Korean                                    | <input type="checkbox"/> Other Race             |
| <input type="checkbox"/> Alaska Native                    | <input type="checkbox"/> Burmese                   | <input type="checkbox"/> Laotian                                   | <input type="checkbox"/> Pakistani              |
| <input type="checkbox"/> American Indian                  | <input type="checkbox"/> Cambodian                 | <input type="checkbox"/> Madagascar                                | <input type="checkbox"/> Polynesian             |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Malaysian                                 | <input type="checkbox"/> Singaporean            |
| <input type="checkbox"/> Arab                             | <input type="checkbox"/> Dominica Islander         | <input type="checkbox"/> Maldivian                                 | <input type="checkbox"/> Sri Lankan             |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Dominican                 | <input type="checkbox"/> Melanesian                                | <input type="checkbox"/> Taiwanese              |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> European                  | <input type="checkbox"/> Micronesian                               | <input type="checkbox"/> Thai                   |
| <input type="checkbox"/> Bahamian                         | <input type="checkbox"/> Filipino                  | <input type="checkbox"/> Middle Eastern or North African           | <input type="checkbox"/> Tobagoan               |
| <input type="checkbox"/> Bangladeshi                      | <input type="checkbox"/> Haitian                   | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Trinidadian            |
| <input type="checkbox"/> Barbadian                        | <input type="checkbox"/> Hmong                     | <input type="checkbox"/> Nepalese                                  | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Bhutanese                        | <input type="checkbox"/> Indonesian                | <input type="checkbox"/> Okinawan                                  | <input type="checkbox"/> West Indian            |
| <input type="checkbox"/> Black                            | <input type="checkbox"/> Iwo Jiman                 |  | <input type="checkbox"/> White                  |
|   | <input type="checkbox"/> Jamaican                  |  |   |

### Please identify your Ethnicity from the following CDC-defined options:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Central American | <input type="checkbox"/> Hispanic or Latino/Spanish   | <input type="checkbox"/> Mexican                | <input type="checkbox"/> South American |
| <input type="checkbox"/> Cuban            | <input type="checkbox"/> Latin American/Latin, Latino | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Spaniard       |
| <input type="checkbox"/> Dominican        |   | <input type="checkbox"/> Puerto Rican           |   |