Cardiothoracic and Vascular Surgeons
1010 W. 40th St
Tel: (512) 459-8753 Fax: (866) 591-1084

HISTORY AND PHYSICAL FORM

Date: _____ Patient Name: _____ DOB: _____

Sex: M / F (*circle one*) **Ht: _____ft:_____in Wt: _____ lbs BP:_____ / _____ Pulse:_____bpm**

EMAIL ADDRESS: _____

REASON FOR TODAY'S VISIT: _____

_____

PROVIDERS: - Pharmacy / Location: _____

- Primary Care Doctor or Clinic / Phone #: _____

- Referring Doctor / Phone #: _____

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

_____

DIALYSIS UNIT: What is the name of your Dialysis Unit and what days do you dialyze? *(if applicable):*

_____

ALLERGIES to Medications: *OR* ❑ **NONE (***no allergies)*

Medication	**Reaction you have**
1	
2	
3	
4	
5	
6	

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

Medication	Dose	How often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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

	Mother ✓	Father ✓	Sister ✓	Brother ✓
Aneurysm				
Bleeding				
Stroke				
Congenital Heart Disease				
Blood Clots (Deep venous thrombosis)				
Diabetes				
Lung disease				
Heart disease				
Heart Failure				
Hyperlipidemia				
High blood pressure				
Kidney Disease				
Cancer (List type of Cancer)				
Heart Attack (MI)				
Obesity				
Renal failure				
Rheumatic Fever				

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**) _____

Year you quit smoking: _____

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

Do you use any other form of tobacco? ❑ yes ❑ no If yes, what type _____

Has tobacco cessation counseling been provided? ❑ yes ❑ no

Alcohol Intake: ❑None ❑Occasional ❑Moderate ❑Heavy

Illicit Drugs: ❑None ❑Yes: (what and how often?) _____

Exercise Level: ❑None ❑Occasional ❑Moderate ❑Heavy

Marital Status: ❑Married ❑Single ❑ Separated ❑Divorced ❑Widowed ❑Domestic Partner

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

DATE	SURGERY

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

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

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)

Constitutional
❑**NONE or:** ❑fever ❑night sweats ❑significant weight gain (_____lbs.) ❑significant weight loss (_____lbs) ❑exercise intolerance ❑fatigue
Comments_____

Eyes
❑**NONE or:** ❑dry eyes ❑eye irritation ❑vision changes
Comments_____

Ears
❑**NONE or:** ❑difficulty hearing ❑ear pain
Comments_____

REVIEW OF SYSTEMS…Continued

Nose

❑**NONE or:** ❑frequent nosebleeds ❑nose/sinus problems
Comments_____

Mouth/Throat

❑**NONE or:** ❑sore throat ❑bleeding gums ❑snoring ❑dry mouth ❑mouth ulcers ❑oral abnormalities ❑teeth problems
Comments_____

Cardiovascular

❑**NONE or:** ❑chest pain ❑chest pain on exertion ❑shortness of breath when walking ❑shortness of breath when lying down ❑palpitations ❑known heart murmur ❑lightheadedness
Comments_____

Respiratory

❑**NONE or:** ❑cough ❑ clear mucus ❑ yellow/green mucus ❑wheezing ❑shortness of breath ❑coughing up blood ❑sleep disturbances (sleep apnea)
Comments _____

Gastrointestinal

❑**NONE or:** ❑abdominal pain ❑vomiting ❑abnormal appetite ❑diarrhea ❑vomiting blood ❑black or tarry stools
Comments_____

Genitourinary

❑**NONE or:** ❑incontinence (loss of urinary control) ❑difficulty urinating ❑increased urinary frequency ❑hematuria ❑change in urinary output ❑incomplete emptying of bladder
Comments_____

Musculoskeletal

❑**NONE or:** ❑muscle aches ❑muscle weakness ❑arthralgias/joint pain ❑back pain ❑swelling in the extremities ❑ needs wheelchair ❑ needs walker
Comments_____

Neurologic

❑**NONE or:** ❑loss of consciousness ❑weakness ❑numbness ❑seizures ❑dizziness ❑frequent/severe headaches ❑migraines ❑restless legs
Comments_____

Hematologic/ Lymphatic

❑**NONE or:** ❑swollen glands ❑bruising ❑easy / excessive bleeding tendency
Comments_____

Allergic/ Immunologic

❑**NONE or:** ❑runny nose ❑sinus pressure ❑itching ❑hives ❑frequent sneezing
Comments_____

Endocrine

❑**NONE or:** ❑excessive thirst or water consumption ❑overall weakness ❑excessive facial or body hair growth ❑temperature intolerance

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.

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

_____
Signature of Patient

_____
Printed Name of Patient

_____ _____
Date **Email**

_____ _____
Guardian or responsible party signature **Relationship to Patient**

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

Cardiothoracic and Vascular Surgeons
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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:

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

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

- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino/Spanish
- ☐ Latin American/Latin, Latino
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard