NEW PATIENT PACKET

COMPREHENSIVE CARDIOVASCULAR

405 Lionel Way, Davenport, FL 33837

320 First St. North, Winter Haven, FL 33881

1110 Druid Circle, Lake Wales, FL 33853

P: (863) 353-1390 | F: (863) 438-4880

www.ccvsfl.com

Please complete the attached packet and bring it with you to your first appointment, along with the following:

Current insurance card(s)
Driver's license or state issued picture ID
Full medication list

By my signature below, I certify that the information in this packet is true and correct to the best of my knowledge.

Patient Signature____

COMPREHENSIVE CARDIOVASCULAR

YOUR INFORMATION

Last Name ______________________ First Name ______________________

Date of Birth _______ /________ /_______ Age ________ Male/Female

Mailing Address ____

Billing Address ____

Home (______) _____-________ Cell (______) _____-_________ Work (______) _____-________

Social Security Number ________-_______-________ Occupation ______________________

E-mail address ______________________________ Number of Children ________

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

EMERGENCY CONTACT

Name ______________________ Relationship to Patient ______________________

Home (______) _____-________ Cell (______) _____-_________ Work (______) _____-________

Address (if different than above): ____

City ______________________ State ______________ Zip ______________

PERMISSION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS & FRIENDS

The following person(s) have permission to access my medical records, to receive information about me and my medical history, and to speak to the physician on my behalf

Name ____________________ Relationship ____________________ Contact # ____________________

Name ____________________ Relationship ____________________ Contact # ____________________

Name ____________________ Relationship ____________________ Contact # ____________________

COMPREHENSIVE CARDIOVASCULAR

PHYSICIAN INFORMATION

Referring Physician ______________________________

Phone # ______________ Name of Practice ______________

Primary Care Physician (Local) ______________________________

Phone # ______________ Name of Practice ______________

Primary Care Physician (North) ______________________________

Phone # ______________ Name of Practice ______________

Previous Cardiologist ______________________________

Phone # ______________ Name of Practice ______________

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? _____ Y _____ N

ARE YOU UNDER A FAMILY MEMBER'S INSURANCE POLICY? _____ Y _____ N

Insured's Information (this is the primary person on the insurance policy)

Last Name ______________ First Name ______________

Date of Birth _______ /________ /_______ Age ________ Male/Female

Address ______________________________

City ______________ State __________ Zip __________

Home (______) _____-________ Cell (______) _____-________ Work (______) _____-________

Social Security Number ________-________-________ Occupation ______________

Relationship to insured (Self/child/other) ______________

Employer ______________ Employment Status __________ Student Status __________

Primary Insurance Carrier/Network ______________________________

ID # ______________ Group # ______________

Secondary Insurance Carrier/Network ______________________________

ID # ______________ Group # ______________

COMPREHENSIVE CARDIOVASCULAR

PATIENT ALLERGY & MEDICATION LIST

Name ______________________________ DOB ________ / ________ / ________

Allergies ____ ☐ No Allergies

Pharmacy ____________________ Pharmacy Phone ____________________

Pharmacy Location ____

MEDICATION	DOSE	FREQUENCY

It is your responsibility to ensure you have enough medication until your next office visit. In the case of an emergency, please call the prescription line, but provide us a one week window to fulfill your request.

COMPREHENSIVE CARDIOVASCULAR

MEDICAL PROBLEMS

PREVIOUS SURGERIES	DATE
1	
2	
3	

Condition	Year	Condition	Year
☐ Angina		☐ Thyroid Disease ☐ Hyper ☐ Hypo	
☐ Coronary Artery Disease		☐ Liver Disease	
☐ Heart Attack		☐ Kidney Disease	
☐ Heart Failure (CHF)		☐ Arthritis	
☐ Heart Valve Disease		☐ Migraine Headaches	
☐ Type:		☐ Seizures	
☐ High Blood Pressure		☐ Stroke	
☐ High Cholesterol		☐ Anemia	
☐ Irregular Heart Rhythm		☐ Bleeding/Clotting Disorder	
☐ Type:		☐ Cancer	
☐ Peripheral Vascular Disease		☐ Type:	
☐ Asthma		☐ GERD	
☐ Lung Disease (COPD)		☐ Depression	
☐ Tuberculosis		☐ Emotional/Behavioral Illness	
☐ Colitis		☐ Explain:	
☐ Stomach Ulcer		☐ AIDS/HIV	
☐ Gout		☐ Other	
☐ Diabetes Type 1 ☐ Type 2 ☐		☐ Explain:	

HAVE YOU EVER HAD THE FOLLOWING TESTS/PROCEDURES?

		Date			Date
Stress Test (Treadmill, etc.)	☐	_____	Tilt Table Test	☐	_____
Holter Monitor	☐	_____	Echocardiogram Carotid	☐	_____
Event Monitor	☐	_____	Ultrasound	☐	_____
Electrophysiologic study (EPS)	☐	_____	Peripheral Ultrasound	☐	_____
Hearth Catheterization	☐	_____	Coronary Angioplasty/Stent	☐	_____
Varicose vein surgery	☐	_____	Heart surgery	☐	_____
Pacemaker	☐	_____	AICD	☐	_____

Angioplasty or stenting in blood vessels other than your heart (e.g legs) ☐ _____

COMPREHENSIVE CARDIOVASCULAR

FAMILY HISTORY

FAMILY HISTORY (Include all known health problems)

Relation to Patient	Age	Living?	Diabetes	Heart Failure	Heart Attack	Stroke	Cancer (Type)	High Cholesterol	Other
Mother		Y/N							
Father		Y/N							
Brother(s)		Y/N							
Sister(s)		Y/N							
Paternal Grandpa		Y/N							
Paternal Grandma		Y/N							
Maternal Grandpa		Y/N							
Maternal Grandma		Y/N							
Father's cause of death				Age	Mother's cause of death				Age

SOCIAL HISTORY

SOCIAL HISTORY (Be as accurate as possible)

Do you exercise regularly? ☐ Yes ☐ No	Type of Exercise? How Often?

TOBACCO USE
(cigarettes, cigars, pipes, and smokeless tobacco)

☐ Never		
☐ I quit (Year ______)	Packs/day?	No. of years?
☐ I still smoke	Packs/day?	No. of years?
☐ Smokeless Tobacco	No. of cans a day?	No. of years?

ALCOHOL & DRUG USE

How often do you drink?	☐ Never	☐ Occasionally	☐ Socially	☐ Daily	☐ Weekly
No. of drinks per week?	___ Beer	___ Red Wine	___ White Wine	___ Liquor	

Any alcohol-related legal, personal or health problem?		
Previous DT's or Seizures?	☐ Yes	☐ No
Treatment for any alcohol-related problem?	☐ Yes	☐ No
Any drug-related legal, personal or health problem?	☐ Yes	☐ No

COMPREHENSIVE CARDIOVASCULAR

VEIN SCREENING FORM

Name ____ DOB ____/____/____

Insurance ____________________________________ Date ______________

VASCULAR HISTORY

Have you ever been diagnosed with:

- ☐ Varicose vein problems — Leg: ___ L ___ R
- ☐ Blood Clots — Leg: ___ L ___ R
- ☐ Phlebitis (Vein Redness) — Leg: ___ L ___ R
- ☐ Deep Vein Thrombosis (DVT) — Leg: ___ L ___ R
- ☐ Saphenous Vein Reflux — Leg: ___ L ___ R

Do you regularly experience any of the following in your leg(s)?

- ☐ Aching/pain — Leg: ___ L ___ R
- ☐ Heaviness — Leg: ___ L ___ R
- ☐ Tiredness/Fatigue — Leg: ___ L ___ R
- ☐ Itching/Burning — Leg: ___ L ___ R
- ☐ Swelling — Leg: ___ L ___ R
- ☐ Cramps — Leg: ___ L ___ R
- ☐ Restless Legs — Leg: ___ L ___ R
- ☐ Throbbing — Leg: ___ L ___ R
- ☐ Skin or Ulcer Problems — Leg: ___ L ___ R
- ☐ Bulging Varicose Veins — Leg: ___ L ___ R
- ☐ Spider Veins — Leg: ___ L ___ R

Which of the following do you currently do to improve your leg vein symptoms?

- ☐ Wear support hose — Leg: ___ L ___ R
- ☐ Medication for pain — Leg: ___ L ___ R
- ☐ Elevation of legs — Leg: ___ L ___ R

VEIN TREATMENT HISTORY

Have you ever bee treated for varicose veins with:

- ☐ Sclerotherapy — Leg: ___ L ___ R
- ☐ Laser Therapy — Leg: ___ L ___ R
- ☐ Phlebectomy — Leg: ___ L ___ R
- ☐ Vein Stripping Surgery — Leg: ___ L ___ R
- ☐ RF Ablation/Endovenous — Leg: ___ L ___ R
- ☐ Laser Therapy — Leg: ___ L ___ R

OFFICE USE ONLY. TO BE COMPLETED BY PROVIDER.

Physical Exam ______________________________

CEAP Clinical Signs __________________________

Right Leg (Check all that apply)

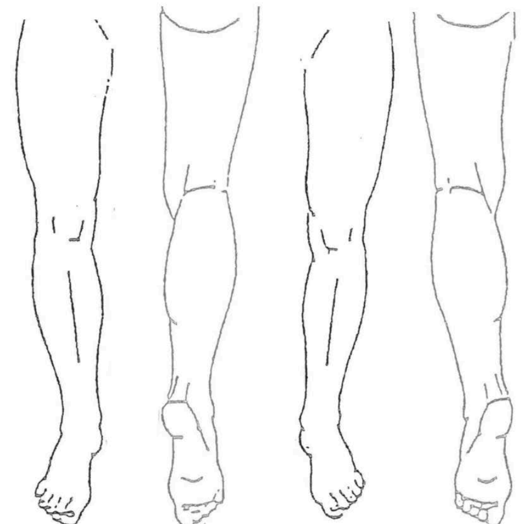
- ☐ No signs of venous disease ☐ Active Ulcers ☐ Edema
- ☐ Visible signs of varicose veins ☐ Healing Ulcers ☐ Pigmentation

Left Leg (Check all that apply)

- ☐ No signs of venous disease ☐ Active Ulcers ☐ Edema
- ☐ Visible signs of varicose veins ☐ Healing Ulcers ☐ Pigmentation

Treatment Plan

- ☐ Duplex Ultrasound ☐ Compression Stockings
- ☐ Schlerotherapy ☐ Other ______________



PROVIDER SIGNATURE ________________________________

COMPREHENSIVE CARDIOVASCULAR

ARTERIAL SCREENING TOOL

Please check all of the below that apply to you

- ☐ Diabetes
- ☐ Current Tobacco use
- ☐ Former tobacco use
- ☐ High blood pressure
- ☐ Heart attack
- ☐ History of stroke/'mini stroke'
- ☐ High cholesterol
- ☐ Stents in your heart
- ☐ Stents in your legs
- ☐ Kidney disease
- ☐ Family history of aneurysm

Do you experience any of the following?

- ☐ Leg pain when walking
- ☐ Leg pain when elevating your legs
- ☐ Difficulty completing house tasks
- ☐ Abdominal pain after meals
- ☐ Difficulty walking
- ☐ Wounds that do not heal
- ☐ Darkening of your skin or nails
- ☐ One arm or leg that is colder than the other

Exercise

Are you able to exercise? ☐ Yes ☐ No

Are you able to walk without limitations? ☐ Yes ☐ No

Do you experience cramping in your calves, thighs, or buttocks when walking? ☐ Yes ☐ No

Is there anything that causes you to stop walking?

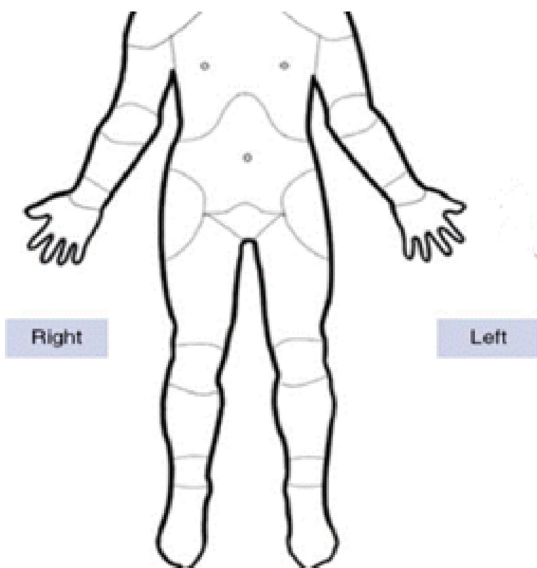
____

____

____

- -

Please mark on the diagram where you have pain



PROVIDER USE ONLY

NUMBER OF RISK FACTORS PRESENT: ____________________

BRUIT: Left Carotid Right Carotid Abdominal

PULSE CHECK

LEFT: Radial Femoral Popliteal DP PT

RIGHT: Radial Femoral Popliteal DP PT

SKIN

Ulcerations Blistering Gangrene Atrophic scars

EXTREMITIES

Decreased sensation Pallor Unilateral decreased capillary refill

MEDICATIONS: ASA Statin Anticoagulation Pletal Trental

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405 Lionel Way, Davenport, FL 33837
Phone: (863) 353-1390 | Fax: (863) 438-4880

MEDICAL RECORDS RELEASE FORM

Patient Name ______________________________ Date of Birth ________________________

Social Security # ______________________________ Phone # __________________________

The undersigned patient named abovehereby executes this authorization in compliance with the Health Insurance Portability and Accountability Act, HIPAA 45 CFR 164.104, and requires that the following health care provider (including its agents, employees, and associates) release his or her records.

RELEASEMEDICALRECORDS

Provider/Hospital Name ____

Provider/Hospital Phone # _________________________ City _____________ State __________

The above named health care provider is required to release the protected information (PHI) as described below to:

COMPREHENSIVE CARDIOVASCULAR
405 Lionel Way, Davenport, FL 33837

RECORDS ARE TO BE FAXED TO (863) 438-4880

The protected health information released herein may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV), drug/alcohol records, and psychiatric/psychological information/records.

Type of information to disclose:

- ☐ All Cardiology Records
- ☐ Visit Notes
- ☐ Vascular Diagnostic
- ☐ Labs
- ☐ Echos
- ☐ Stress Tests
- ☐ Heart Monitors
- ☐ EKGs
- ☐ Device Checks
- ☐ Other/Specified Date ______________________________________

____

A. Purpose of Disclosure Medical Care Other:

B. This authorization may be revoked at any time by a signed and properly dated written revocation sent to the specific health care provider being provided with the request, but this release cannot be revoked as to protect health information that had been previously released in reliance on this document.

C. I understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations. CCVS cannot guarantee that the recipient of the information will not re-disclose this information.

____ ______________

Patient's Signature/Legal Representative Signature (specify relationship) Date