PATIENT DATA SHEET



Main Number: (248) 545-0070

PERSONAL DATA **ADDRESS** LAST NAME STREET APT # _____ CITY _____ FIRST Date of Birth _____ Gender ____ STATE _____ZIP ____ MARRIED _____ SINGLE ____ SEP ____ Home Phone ALTERNATE PHONE _____ Social Security Number EMERGENCY CONTACT _____ EMERGENCY PHONE PLEASE LET US KNOW THE INDIVIDUAL(S) THAT WE MAY THEIR RELATIONSHIP TO YOU DISCLOSE YOUR HEALTH INFORMATION TO (IN THE FORM OF PHONE DISCUSSION / MESSAGES): I GIVE MY AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING: DATE SIGNATURE EMPLOYMENT AND REFERRAL DATA REFERRED BY OCCUPATION ______ PERSONAL PHYSICIAN _____ EMPLOYER STREET STREET CITY/STATE_____ ZIP _____ CITY Work Phone ______ Phone _____ SPOUSE NAME _______ SPOUSE EMPLOYER _____ I AUTHORIZE THE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO CARDIOLOGY ASSOCIATES, P.C. (d.b.a. NORTHPOINTE HEART CENTER) AND, AS SUCH, I AUTHORIZE THE RELEASE OF PERTINENT INFORMATION TO THE INSURANCE CARRIERS. I UNDERSTAND THAT AM FULLY RESPONSIBLE FOR ALL SERVICES INCLUDING THOSE THAT ARE CONSIDERED REJECTED, CO-PAY, DEDUCTIBLES OR OTHER TYPE OF UNPAID SERVICES.

PATIENT'S SIGNATURE DATE



PERSON	IAL DATA		D
I AST NAME			PARENT
LAST NAME			PARENT
FIRST MI			PRESSUI
D D	0		HAVE YO
DATE OF BIRTH	GEND	ER	YEAR
		_	STILL
KNOWN A	ALLERGIE	S	CIGAF
			OUNCES
			BEER/W
			PAST EX WHE
145010.4			Do you
_	TION DATA		WHAT
PLEASE LIST ALL CURRENT M	EDICATIONS	o.	TIMES
MEDICATION	DOSE	HOW OFTEN	How
			WHENW
			CHOLES
			TOTA
			TRIGI
			LDL Do you
			DIET?
			WEIGHT
			LICTAND
			LIST AN'
HEALTH ST	TATUS DA	TA	
PLEASE CHECK IF YOU HAVE	A HISTORY	OF:	
μ Α ΝΕΜΙΑ	μ HEART	ATTACK	LIST AN
μ Ankle/Feet Swelling	μ HEART	FAILURE	
μ Anxiety/Depression	•	BLOOD PRESSURE	
μ ARTHRITIS	μPALPI		PAST HE
•	•	MATIC FEVER	WHE
μ ASTHMA	μ KHEUN		WHE
•	•	RES	, vvn-
μ CANCER	μ SEIZUI		
μ Cancer μ Chest Pain/Tightness	μ SEIZUF μ SHORT	NESS OF BREATH	Past H
μ CANCER μ CHEST PAIN/TIGHTNESS μ DIABETES	μ SEIZUF μ SHORT μ THYRO	NESS OF BREATH	PAST H
μ Cancer μ Chest Pain/Tightness	μ SEIZUF μ SHORT μ THYRO	TNESS OF BREATH DID PROBLEM	PAST HI WHEI

RISK FACTOR DATA PARENT OR SIBLING WITH HEART DISEASE BEFORE AGE 65 PARENT OR SIBLING WITH HIGH BLOOD PRESSURE OR DIABETES HAVE YOU BEEN A SMOKER? STILL SMOKE? CIGARETTES/DAY? OUNCES OF LIQUOR CONSUMED/DAY BEER/WINE GLASSES/DAY PAST EXERCISE/STRESS TEST WHEN AND WHERE? DO YOU EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? #YES #NO WEIGHT ONE YEAR AGO			
DISEASE BEFORE AGE 65 PARENT OR SIBLING WITH HIGH BLOOD PRESSURE OR DIABETES HAVE YOU BEEN A SMOKER? YEAR QUIT? STILL SMOKE? CIGARETTES/DAY? OUNCES OF LIQUOR CONSUMED/DAY BEER/WINE GLASSES/DAY PAST EXERCISE/STRESS TEST WHEN AND WHERE? DO YOU EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? #YES #NO	RISK FACTOR DATA		
PRESSURE OR DIABETES HAVE YOU BEEN A SMOKER? YEAR QUIT? STILL SMOKE? CIGARETTES/DAY? OUNCES OF LIQUOR CONSUMED/DAY BEER/WINE GLASSES/DAY PAST EXERCISE/STRESS TEST WHEN AND WHERE? DO YOU EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? HYES \$\mu\$NO	DISEASE BEFORE AGE 65	μYES	μ Νο
YEAR QUIT? STILL SMOKE? CIGARETTES/DAY? OUNCES OF LIQUOR CONSUMED/DAY BEER/WINE GLASSES/DAY PAST EXERCISE/STRESS TEST WHEN AND WHERE? DO YOU EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? #YES #NO		μYES	μ Νο
CIGARETTES/DAY? OUNCES OF LIQUOR CONSUMED/DAY BEER/WINE GLASSES/DAY PAST EXERCISE/STRESS TEST		μ YES	μΝο
BEER/WINE GLASSES/DAY PAST EXERCISE/STRESS TEST		μYES	μ Νο
PAST EXERCISE/STRESS TEST WHEN AND WHERE? DO YOU EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? μYES μNO	OUNCES OF LIQUOR CONSUMED/DAY		
WHEN AND WHERE? DO YOU EXERCISE? WHAT KIND OF EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO	BEER/WINE GLASSES/DAY		
DO YOU EXERCISE? WHAT KIND OF EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO		μYES	μ Νο
WHAT KIND OF EXERCISE? TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO			
TIMES/WEEK HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO		μYES	μΝο
HOW LONG? WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO			
WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO	TIMES/WEEK		
CHOLESTEROL LEVEL LAST CHECKED? TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO	How Long?		
TOTAL CHOLESTEROL TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO			
TRIGLYCERIDES LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO	CHOLESTEROL LEVEL LAST CHECKED?		
LDL DO YOU FOLLOW A LOW CHOLESTEROL DIET? µYES µNO	TOTAL CHOLESTEROL		
DO YOU FOLLOW A LOW CHOLESTEROL μYES μNο	TRIGLYCERIDES		
DIET? μYES μNο	LDL		
WEIGHT ONE YEAR AGO		μYES	μ Νο
	WEIGHT ONE YEAR AGO		

MISCELLANEOUS DAT	Α
LIST ANY OTHER MAJOR ILLNESSES:	
LIST ANY MAJOR OPERATIONS:	
PAST HEART SURGERY?	μ YES μ NO
WHEN?	
WHERE?	
PAST HEART CATHETERIZATION?	μYES μNO
WHEN?	
WHERE?	