Mary Washington Cardiology

Patient Registration

Date:_____

Patient Information

Legal Name: _____ Date of Birth: _____ / _____ / _____

Preferred Name (If different from legal name): _____

Preferred Pronoun (Please circle): She / Her He / Him They / Them

Race: ❑ American Indian or Alaska Native ❑ Asian
❑ Black or African American ❑ White
❑ Decline to provide ❑ Other

Ethnicity: ❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Decline to provide

Preferred language (if not specified, English will be chosen as your preferred language):_____

Contact preference: ❑ Mobile /texting ❑ Home Phone ❑ Work Phone ❑ Email (provide email address)

Home Address:_____

Mailing Address (if different) _____

Home Phone: _____ Mobile Phone:_____ Work Phone:_____

Primary Care Physician:_____ Referring Physician:_____

Pharmacy Name: _____Address:_____

Guarantor / Responsible Party

Name:_____ Date of Birth: _____ / _____ / _____

Relationship to patient: ❑ Self ❑ Parent ❑ Legal Guardian ❑ Family Member ❑ Other:_____

Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____

Home Address:_____

Mailing Address (if different) _____

Emergency Contact(s)

Name:_____ Phone: _____

Relationship to patient: ❑ Parent ❑ Legal Guardian ❑ Family Member ❑ Other: _____

Home Address:_____ City:_____ State:_____ Zip: _____

Name:_____ Phone: _____

Relationship to patient: ❑ Parent ❑ Legal Guardian ❑ Family Member ❑ Other: _____

Home Address:_____ City:_____ State:_____ Zip: _____

Insurance PRIMARY INSURANCE

Name:_____ Address:_____

Subscriber/Member ID #: _____ Employer: _____

Subscriber Name: _____ Date of Birth: _____ / _____ / _____

Group #:_____ Relationship to patient:_____

Insurance SECONDARY INSURANCE

Name: _____ Address: _____

Subscriber/Member ID #: _____ Employer: _____

Subscriber Name: _____ Date of Birth: _____ / _____ / _____

Group #: _____ Relationship to patient: _____

Please Answer All Questions

What is your reason for today's visit? _____

1. When did the problem/discomfort start? _____
2. Where is the problem/discomfort located? _____
3. What makes it worse? _____
4. If there are any other symptoms associated with this problem please describe _____

_____

General Review Of Systems Are you currently having any of the following symptoms? (Please circle yes or no)

Constitutional:
Y N Recent weight change
Y N Fever
Y N Chills
Y N Fatigue

Eyes:
Y N Blurred/impaired vision

ENT:
Y N Hearing loss
Y N Ringing in ears
Y N Nose bleeds
Y N Bleeding gums
Y N Sore throat or voice change
Y N Swollen glands in neck

Cardiovascular:
Y N Chest pains/discomfort
Y N Sudden heart beat changes
Y N Palpitations/racing heart beat
Y N Swelling of feet, ankles or hands

Respiratory:
Y N Frequent coughing
Y N Sputum productive cough
Y N Spitting up blood
Y N Shortness of breath
Y N Asthma or wheezing

Gastrointestinal:
Y N Loss of appetite
Y N Change in bowel movements
Y N Nausea
Y N Vomiting
Y N Frequent diarrhea
Y N Painful bowel movements/ constipation
Y N Blood in stool
Y N Stomach pain
Y N Heartburn
Y N Reflux

Genitourinary:
Y N Frequent urination
Y N Burning or painful urination
Y N Blood in urine
Y N Incontinence or dribbling
Y N Kidney stones
Y N Sexual difficulty
Y N Erection Problems

Musculoskeletal:
Y N Joint pain
Y N Joint stiffness or swelling
Y N Weakness of muscles/joints
Y N Muscle pain or cramps
Y N Back pain
Y N Cold extremities
Y N Leg pain with walking
Y N Leg swelling
Y N Limb weakness

Skin:
Y N Rash
Y N Itching skin
Y N Change in skin color
Y N Varicose veins
Y N Easily bruise
Y N Non-healing sores

Psychiatric:
Y N Memory loss or confusion
Y N Nervousness
Y N Depression
Y N Sleep problems
Y N Suicidal thoughts

Neurological:
Y N Syncope/Passing out
Y N Near Syncope
Y N Headaches
Y N Lightheaded
Y N Dizziness
Y N Convulsions or seizures
Y N Numbness or tingling
Y N Tremors
Y N Paralysis
Y N Stroke
Y N Head injury
Y N Slurred speech

Endocrine:
Y N Thyroid disease
Y N Diabetes
Y N Excessive thirst
Y N Excessive urination
Y N Heat or cold intolerance
Y N Dry skin

Hematologic/Lymphatic:
Y N Slow to heal after cuts
Y N Bleeding tendencies
Y N Anemia

List all allergies that you have:

_____

_____

_____

_____

Please list all PRESCRIPTION medications that you take

Name	Dose	Frequency

List all OVER THE COUNTER medications that you take

Name	Dose	Frequency

Past Medical History: (Check all that apply)

- ❑ Heart Disease
- ❑ Heart Valve Problems
- ❑ Pacemaker
- ❑ Heart Failure
- ❑ Heart Block
- ❑ Hereditary Heart Defect
- ❑ Heart Murmur Previous ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Blood Clot in Legs
- ❑ Blood Clot in Lungs
- ❑ Lung Problems
- ❑ Emphysema
- ❑ Asthma
- ❑ COPD
- ❑ Thyroid Disease
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Stroke
- ❑ Diabetes
- ❑ Cancer
- ❑ Bleeding Disorder
- ❑ HIV Disease/exposure
- ❑ Hepatitis (A, B or C)

Please provide information about previous surgeries and hospitalizations (include date or year)

Surgeries / Procedures

Coronary Bypass_____ Date_____

Cardiac Cath _____ Date_____

Angioplasty / Stent _____ Date_____

Pacemaker_____ Date_____

Defibrillator _____ Date_____

Other _____ Date_____

_____ Date_____

Hospitalizations

Admitted for _____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

Please provide information about previous testing (include date and location)

Stress Test _____Date _____Location _____

Nuclear Test _____Date _____Location _____

Echo _____Date _____Location _____

24 hr BP Monitor _____Date _____Location _____

Holter Monitor _____Date _____Location _____

Event Monitor_____Date _____Location _____

Heart Scan _____Date _____Location _____

PAD Testing_____Date _____Location _____

Does anyone in your family have or had Heart Disease, Heart Attack, Stroke, High Cholesterol, High Blood Pressure, Diabetes, Sudden Death or Cancer?

❑ Father Age_____ Disease(s) _____ Cause of death, if deceased _____

❑ Mother Age_____ Disease(s) _____ Cause of death, if deceased _____

❑ Siblings Age_____ Disease(s) _____ Cause of death, if deceased _____

❑ Siblings Age_____ Disease(s) _____ Cause of death, if deceased _____

❑ Siblings Age_____ Disease(s) _____ Cause of death, if deceased _____

Social History:

Use of Tobacco: ❑ Yes ❑ No Explanation:_____ Previous ❑ Yes ❑ No Year Quit _____

Use of Alcohol: ❑ Yes ❑ No | Caffeine: ❑ Yes ❑ No | Special Diet: ❑ Yes ❑ No _____

Patient Signature:_____ Date: _____