

Fainting	Yes	No	When: _____
Near-Fainting	Yes	No	When: _____
Cardiac Arrest	Yes	No	When: _____
Shortness of Breath	Yes	No	When: _____
Chest Discomfort	Yes	No	When: _____
Leg Swelling	Yes	No	When: _____
Congestive Heart Failure	Yes	No	When: _____



Dear Valued Patient,

We are writing to announce a major change in our medical practice. We are converting our paper charts to an Electronic Medical Records (EMR) system. Our intention is to implement a smooth and seamless transition with minimal impact to you while continuing to provide the highest level of patient care.

You should be assured that whether you are a new or existing patient, we remain committed to superior service and exceptional patient care during this transition.

What does this mean for you?

Enclosed you will find a three (3) page packet and self addressed, stamped envelope. Please fill out and return this packet to us as soon as possible. **We need your help to ensure the data entered into our new EMR system is the most up to date possible.** We understand that some of the data may not have changed and we apologize for any inconvenience this may cause, however validating this information is required to create your profile and new electronic medical chart.

To minimize your wait time and ensure scheduled appointment timelines, it is essential we update your data prior to your next appointment. ***Please note that if we have to update this data at the time of your appointment it will cause a delay as we will need to input your data and create your chart before your physician can see you.**

Due to the large number of patients in our system, and in an effort to maximize efficiency, we will be converting one (1) or two (2) physicians at a time. In turn, this will help keep appointments running in a timely manner. We anticipate there may be some small delays, but we believe they will be kept to a minimum using this approach.

We would like to say thank you in advance for your patience and understanding during this transition. Our goal is to make the transition to EMR as smooth and seamless as possible for you. We will be doing everything in our power to insure that all of your personal data is entered and ready for when your physician converts to electronic medical records.

Thank you for selecting Pima Heart Physicians, Pc for your Cardiovascular Care.

HOSPITALIZATIONS

Reason for Hospitalization	Year	Hospital (City)
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? (Please check all that apply)

Cardiac/ Vascular	Chest Pains or angina	<input type="checkbox"/>	Swelling of feet, ankles, hands	<input type="checkbox"/>
	Palpitations	<input type="checkbox"/>	Leg pain with walking	<input type="checkbox"/>
	Syncope (fainting)	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>
Constitutional	Recent Weight Change	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Respiratory	Chronic or Frequent Coughs	<input type="checkbox"/>	Spitting up Blood	<input type="checkbox"/>
	Shortness of Breath on Exertion	<input type="checkbox"/>	Shortness of Breath at rest	<input type="checkbox"/>
	Asthma or Wheezing	<input type="checkbox"/>	Snoring	<input type="checkbox"/>
Gastrointestinal	Loss of appetite	<input type="checkbox"/>	Nausea or Vomiting	<input type="checkbox"/>
	Blood in Stool	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>
Musculoskeletal	Joint Pain	<input type="checkbox"/>	Muscle weakness or pain	<input type="checkbox"/>
Skin/ Derm	Rash	<input type="checkbox"/>	Skin Sores	<input type="checkbox"/>
Neurological	Frequent Headaches	<input type="checkbox"/>	Lightheaded or Dizzy	<input type="checkbox"/>
	Seizures	<input type="checkbox"/>	Stroke or TIA	<input type="checkbox"/>
	Tremors	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>
Psychiatric	Nervousness or Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>
	Difficulty Sleeping	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>
Genitourinary	Blood in Urine	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>
	Painful or Burning Urination	<input type="checkbox"/>		
Hemetologic	Anemia	<input type="checkbox"/>	Bleeding or Bruising tendency	<input type="checkbox"/>
HEENT	Hearing Loss	<input type="checkbox"/>	Vision Changes	<input type="checkbox"/>

Signature of Patient

Date



PATIENT HISTORY

Name: _____ **Home Phone** _____ **Cell Phone** _____
DOB: _____ **Age:** _____ **Occupation** _____
Patient Address: _____ **Patient Emergency Contact:** _____
Preferred Pharmacy: _____ **Preferred Pharmacy Location (^{CROSS} streets):** _____
Retired: Y or N **If retired, previous occupation:** _____
Marital Status: Single Married Separated Divorced Widowed **Living Will?** Yes No
Name of Spouse: _____ **Contact Number:** _____
Referring Doctor: _____ **Primary Care Doctor:** _____

SOCIAL HISTORY

Tobacco Use Yes _____ No _____ Former _____ Year Quit: _____ Packs _____ Yrs Smoked: _____	Alcohol Use Yes _____ No _____ Former _____ How much? _____ Exercise Active Sedentary Regular Occasional	Caffeine Use Yes _____ If YES, what? _____ No _____
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Drug Abuse/Use
 Yes _____
 No _____
 Type _____
 Duration _____

List problems with mobility or self care: _____

Do you use any medical equipment at home? (Circle all that apply)
 Wheelchair Walker Crutches Cane Prothesis
 Home Oxygen Other breathing device

FAMILY HISTORY

Family History of CAD?	Yes	No	Unsure	Adopted?	Yes	No
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Mother Alive (age) _____ Deceased _____ Cause? _____
Health Problems: _____
Father Alive (age) _____ Deceased _____ Cause? _____
Health Problems: _____
Brothers Alive (age) _____ Deceased _____ Cause? _____
Health Problems: _____
Sisters Alive (age) _____ Deceased _____ Cause? _____
Health Problems: _____
Children Alive (age) _____ Deceased _____ Cause? _____
Health Problems: _____

MEDICATIONS

CURRENT MEDICATIONS

Drug	Dosage	How many times per day?

DRUG ALLERGIES	MEDICATIONS CONTINUED...		
Drug			Reaction(s)

ADDITIONAL ALLERGIES (foods, adhesive tape, X-Ray contrast, latex, etc.) Yes No
Allergy _____ **Reaction** _____

SURGERIES AND PROCEDURES

Heart Surgery? Yes No (i.e. Coronary Bypass, Valve Replacement, Transplant, etc) Vascular Surgery? Yes No (i.e. Bypass Graft, Angioplasty, Stents, etc) Cardiovascular Procedures/ Intervention Yes No (i.e. Cath/Angiogram, Stents, PTCA, etc) Do you have difficulty with anesthesia? Yes No Other Surgeries: Type: _____ Type: _____	Date _____ Facility _____ Surgery _____ Date _____ Facility _____ Surgery _____ Date _____ Facility _____ Procedure _____ Date _____ Facility _____ Surgery _____ Date _____ Facility _____ Surgery _____ Yes No Age: _____ Have you had a total hysterectomy (ovaries and uterus removed)? Do you take birth control pills? Have you gone through menopause? Are you taking hormone replacement?
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PERSONAL HISTORY AND RISK FACTORS

Have you been diagnosed with:
 Diabetes Yes No When: _____
 Dyslipidemia (Increase of lipids in blood) Yes No When: _____
 Hypertension (High Blood Pressure) Yes No When: _____
 Peripheral Vascular Disease Yes No When: _____
 Heart Valve Disease Yes No When: _____
 Thyroid Disorder Yes No When: _____
 Bleeding Tendencies Yes No When: _____
 Kidney Problems Yes No When: _____
 Lung Disease Yes No When: _____
 Stroke Yes No When: _____
 Heart Attack (myocardial infarction) Yes No When: _____

Have you ever experienced or have been diagnosed with:
 Palpitations (racing heart or skipped beats) Yes No When: _____