aurora denver cardiology associates

NEW PATIENT MEDICAL HISTORY FORM

Full Name:________________________________ Birth Date:______________ Date of Service:_________

Primary Care Physician (PCP): __________________________________ PCP Phone #:________________

Other Specialist Name/ Specialty:_________________________ Last Seen:_________Phone#:_________

Pharmacy Name:___________________________________ Address/Location:______________________

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Abnormal Heart Rhythm			
Alcoholism/Drug Abuse			
Asthma			
Autoimmune Disorder *(type:___________________)*			
Cancer *(type:__________________________)*			
Chest Pain			
Diabetes *(type:________________________)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Murmur			
Renal *(kidney)* Disease			
Stroke			
Valvular Disease			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

HOSPITALIZATIONS

Reason:	Date:	Facility:

ALLERGIES

Allergy:	Reaction:

FAMILY MEDICAL HISTORY

☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

Check All That Apply	Asthma	Cancer (type:)	Emphysema (COPD)	Diabetes	Early Death	Heart Disease	Heart Attack	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Pacemaker	Thyroid Disease	Other:____	Other:____
Mother															
Father															
Brother															
Sister															
Child															
Maternal Grandmother															
Maternal Grandfather															
Paternal Grandmother															
Paternal Grandfather															
Other:__________________															

SOCIAL HISTORY

Occupation *(or prior occupation)*:	☐ Retired ☐ Unemployed ☐ LOA ☐ Disabled
Marital Status *(check one)*: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other:______________	

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*
Current: Packs/day______# of Years _______	***Past:*** Quit Date:__________________Packs/day_______# of Years _______
Other Tobacco *(check one)*: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew	

ALCOHOL/DRUG/ CAFFEINE USE	Do you drink alcohol? Y N	☐ Beer ☐ Wine ☐ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Caffeine intake? Y N How many cups daily:___________	

Deaf or serious difficulty hearing: Y N	Blind or serious difficulty seeing: Y N
Difficulty concentrating, remembering or making decisions: Y N	Difficulty walking or climbing stairs: Y N
Difficulty dressing or bathing: Y N	Difficulty doing errands alone: Y N

Patient Name: ____ DOB: ______________________

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Patient Name____ Date of Service____________________

Review of Systems-New Patient

Please circle any problems you have been having or check "No Problems"

Constitutional: ___ ***No Problems***

fever , night sweats , weight gain (___lbs) , weight loss (___ lbs) , fatigue

Cardiovascular: ___ **No Problems**

chest pain, arm pain with exertion, chest fluttering or palpitations, sleeping with more than one pillow, passing out or fainting, edema (swelling)

Eyes: ___ **No Problems**

dry eyes, vision changes, irritation, glasses or contacts

ENMT: ___ **No Problems**

Ears: difficulty hearing , ear pain, ringing, ear drainage

Nose: frequent nosebleeds, nose/sinus problems

Mouth/Throat: sore throat, mouth ulcer, teeth abnormalities, snoring

Respiratory: ___**No Problems**

Shortness of breath, shortness of breath with activity, shortness of breath when lying flat, cough, wheezing

Gastrointestinal: ___**No Problems**

abdominal pain, vomiting, change in appetite, frequent diarrhea, vomiting blood, heartburn, nausea, constipation

Genitourinary: ___**No Problems**

Difficulty urinating, blood in urine, increased urine frequency, change in libido, incontinence

Musculoskeletal: ___**No Problems**

Muscle aches, muscle weakness, arthralgia (joint pain), back pain, swelling in the extremities

Skin: ___**No Problems**

Jaundice (yellowing of skin), rash, itching, dry skin, growths/legions, easy bruising, excessive bleeding, swollen glands

Neurologic: ___**No Problems**

Loss of consciousness, weakness, seizures, numbness, dizziness, frequent or severe headaches

Psychiatric: ___**No Problems**

Depression, sleep disturbances, anxiety, excessive stress

Endocrine: ___ **No Problems**

Diabetes, thyroid problems, increased thirst, excessive sweating, cold or heat intolerance

Hematologic ___ **No Problems**

Easy bruising, excessive bleeding, swollen glands

Patient Signature____

___Reviewed All Systems With Patient Physician Signature_______________________________________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT (Please print)

***TO THE PATIENT*: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).**

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: ________________________________ Date: __________________

Printed name of patient or personal representative: _____________________________ Relationship to patient: _____

Patient name: ____________________________

Date of birth: _____________________________