NORTHEAST OKLAHOMA
HEART CENTER

PATIENT INFORMATION

Name: _____ Date of Birth: _____ SEX: ☐M ☐F

Social Security Number: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Business Phone: _____

Marital Status: _____ Ethnicity: _____

Spouse/Parent Name: _____ Spouse/Parent Birthdate: _____

Spouse/Parent SSN: _____ Spouse/Parent Phone Number: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Co: _____

ID: _____ Group Name and Number: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Subscriber Relationship: _____ Subscriber Employer: _____

Secondary Insurance Co: _____

ID: _____ Group Name and Number: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Subscriber Relationship: _____ Subscriber Employer: _____

CLINICAL HISTORY

Allergies:

_____

_____

MEDICAL HISTORY Check (✓) the medical conditions you have or have had.

☐ AIDS / HIV positive	☐ Diabetes	☐ Liver Disease	☐ Tonsillitis
☐ Anemia	☐ Emphysema	☐ Migraine Headaches	☐ Thyroid problems
☐ Anorexia / Bulimia	☐ Epilepsy	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Arthritis	☐ Gall Bladder Disease	☐ Pacemaker	☐ Ulcers
☐ Asthma	☐ Goiter	☐ Pneumonia	☐ Other
☐ Bleeding disorders	☐ Gout	☐ Prostate Problem	
☐ Blood in urine	☐ Heart Disease	☐ Rheumatic Fever	
☐ Bronchitis	☐ Hepatitis	☐ Scarlet Fever	
☐ Cancer	☐ Hernia	☐ Stroke	
☐ Chemical Dependency	☐ Kidney Stones/Disease	☐ Suicide attempt	

SURGICAL HISTORY (Include year and surgery description)

_____

_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: _____

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FAMILY HISTORY (Fill in health information about your family)

	Age	State of Health	Age of Death	Cause of Death
Example	27	Fair	Living	NA
Father				
Mother				
Brother				
Sister				

Do any of the following exist in your blood relatives? (Check all that apply)

☐ Arthritis, Gout	☐ Dialysis	☐ Kidney Disease	☐ Other _____
☐ Cancer	☐ Hearth Disease, Stroke	☐ Kidney Stones	☐ Other _____
☐ Diabetes	☐ High Blood Pressure	☐ Tuberculosis	☐ Other _____

SOCIAL HISTORY

Do/Did You Smoke? ☐ Yes ☐ No How Much? _____ Packs/Day # Of Years _____ Year You Quit _____

Do/Did You Drink Alcohol? ☐ Yes ☐ No How Much? _____ Drinks/Week # Of Years _____ Year You Quit _____
Previous or Current Problems With Alcohol? _____

Do You or Have You Used? (CHECK) ☐ Illicit Drugs ☐ Chewing Tobacco ☐ Diet Pills

WOMEN

Age at First Period _____ Date of Last Normal Period _____ # Of Pregnancies _____

Of Live Births _____ # Of Children Living With You _____ # Of Abortions/Miscarriages _____

Problems With Pregnancies (CHECK) ☐ Pre-term Labor ☐ Toxemia ☐ Diabetes ☐ High Blood Pressure Other:

Any other information you feel the doctor should know?

Northeastern Oklahoma Heart Center, as a courtesy to the patient, is enrolled with numerous insurance companies. We will make every possible effort to verify coverage and bill your insurance company appropriately. However, it is the patient's responsibility to know the details of his/her insurance plan. All copay's and patient portion amounts will be due at time of service. I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

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MEDICATION LIST

Patient Name: _____ DOB: _____

Phone #: _____ Pharmacy: _____

ALLERGIES

MEDICATION LIST			
Medication	**Dosage**	**How Often Taken**	**Prescribing Doctor**

YOU MUST BRING ALL MEDICATIONS IN THEIR BOTTLES TO ALL APPOINTMENTS

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REVIEW OF SYSTEMS

Check (✓) the medical conditions you have or have had since your last cardiac visit.

CARDIOVASCULAR	PSYCHIATRIC	EYES, EARS, NOSE & THROAT
☐ Chest Pain ☐ Chest Tightness ☐ Irregular Heart Beat ☐ Dizziness ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Swelling of Ankles	☐ Anxiety ☐ Depression	☐ Acute Changes in Vision ☐ Bleeding Gums ☐ Blurred Vision ☐ Changes in Hearing ☐ Difficult Swallowing ☐ Loss of Hearing ☐ Nasal Discharge ☐ Nasal Congestion ☐ Sinus Problems
RESPIRATORY	**ENDOCRINE**	**GI/STOMACH**
☐ Cough ☐ Difficulty Breathing ☐ Shortness of Breath ☐ Wheezing	☐ Diabetic Disorder ☐ Excessive Thirst ☐ Excessive Urination ☐ Thyroid Disorder	☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ Indigestion/Heartburn ☐ Nausea ☐ Vomiting
GENITO-URINARY	**ALLERGY/IMMUNOLOGIC**	**MUSCLE/JOINT/BONE/PAIN, WEAKNESS, NUMBNESS IN:**
☐ Blood in Urine ☐ Frequent Urination ☐ Lack of Bladder Control ☐ Painful Urination	☐ Iodine Allergy ☐ Latex Allergy	☐ Arm ☐ Back ☐ Feet ☐ Hips ☐ Legs ☐ Neck
SKIN	**HEMATOLOGIC/LYMPHATIC**	**OTHER**
☐ Bruise Easily ☐ Hives/Itching ☐ Wounds	☐ Anemia ☐ Bleeding Disorder ☐ Clotting Disorder	
NEUROLOGY	**GENERAL**	
☐ Dizziness ☐ Loss of Consciousness ☐ Stroke ☐ Weakness	☐ Chills/Fever ☐ Weight Gain-Intentional/Unintentional ☐ Weight Loss – Rapid/Gradual	

Anything else you feel the doctor needs to know?

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any member of the staff responsible for any errors or omissions that I may have made in completion of this form. I consent to examination/treatment/surgery if indicated by the physicians of Northeast Oklahoma Heart Center.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____