

Registration Form

PATIENT INFORMATION

Patient's Full Name: _____ DOB: _____

Current Address: _____ Last 4 digits of SSN: _____

City/State/Zip: _____ Marital Status: _____

Phone Number: _____ Cell Number: _____

Primary Care MD: _____ Referring MD: _____

Date of Procedure: _____ Type of Procedure: _____

Do you have an Advanced Directive for healthcare? Y/N

Would you like more information about an Advanced Directive for healthcare? Y/N

EMPLOYMENT INFORMATION

Employer: _____ Employer Phone Number: _____

Employer Address: _____

City/State/Zip: _____

If retired, please give date: _____

Spouse Retirement date: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

City/State/Zip: _____

Medical Assessment

Name _____

Date of Birth _____

Referring Physician _____

Primary Physician _____

Cardiac Procedures (estimate most recent date)

Stress Test _____

Bypass Surgery _____

Echo _____

Valve Repair/Replacement _____

Heart Cath _____

Pacemaker _____

Angioplasty/Stent _____

AICD _____

Cardiovascular History (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Irregular/Rapid Heartbeat | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Leg Cramps while walking |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Family History of Heart Disease |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Chest Pain with or without exertion |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Shortness of Breath with or without exertion |

Do you carry Nitroglycerin? Y/N

Respiratory History (Check all that apply)

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Use Oxygen at home |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> COPD | <input type="checkbox"/> Other _____ |

General History (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hypo or Hyperthyroidism | <input type="checkbox"/> GERD | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Chronic Back Pain/Injury |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Dizziness | |

Loss of Sensation in arms/legs (if yes, describe) _____

Joint Replacement surgery (if yes, describe) _____

Other Joint surgery (if yes, describe) _____

Do you Smoke? Y/N if yes # pks per day _____ if quit, approx date _____

Do you exercise regularly? Y/N (if yes, describe) _____

Height _____ Weight _____ Recent loss/gain _____

