Health Connections

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: _____

Email: _____ Mother's Maiden Name: _____

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

Are you receiving black lung benefits? Y/N

Do you have End Stage Renal disease? Y/N

EMPLOYMENT INFORMATION

Employer: _____ Employer Phone Number: _____

Employer Address: _____

City/State/Zip: _____

If retired, please give date: _____

Spouse's Employer: _____ Spouse Retirement date: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

City/State/Zip: _____

NEXT OF KIN

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)

Have you ever been told you have any of the following:

( ) High Blood Pressure ( ) Stroke ( ) Angina
( ) Irregular/Rapid Heartbeat/Atrial fibrillation ( ) Aneurysm/Abdominal Aortic
( ) Palpitations ( ) Leg Cramps while walking
( ) Congestive Heart Failure ( ) High Cholesterol
( ) Cardiomyopathy ( ) Family History of Heart Disease
( ) Murmur ( ) Chest Pain with or without exertion
( ) Coronary Artery Disease ( ) Shortness of Breath with or without exertion

Do you carry Nitroglycerin? Y/N

Respiratory History (Check all that apply)

Have you ever been told you have any of the following:

( ) Asthma ( ) Emphysema ( ) Use Oxygen at home ( ) Other _____
( ) Chronic Bronchitis ( ) COPD ( ) Sleep Apnea

General History (Check all that apply)

Have you ever been told you have any of the following:

( ) Diabetes ( ) Indigestion/GERD ( ) Headaches ( ) Dizziness
( ) Hypo or Hyperthyroidism ( ) Cancer ( ) Arthritis
( ) Kidney Disease ( ) Hiatal Hernia ( ) Chronic Back Pain/Injury
( ) Dialysis ( ) Seizures ( ) Degenerative Disc Disease

Do you Smoke? Yes/No if yes # pks per day _____ if quit, approx date _____
Do you drink alcohol? Yes/No if yes # drinks per day _____

Musculoskeletal (Check all that apply)

Yes/No Loss of Sensation in arms/legs (if yes, describe) _____
Yes/No Joint Replacement surgery (if yes, describe) _____
Yes/No Other orthopedic issues (if yes, describe) _____
Do you exercise regularly? Yes/No How often? _____ Type? _____

Height _____ Weight _____ Recent loss/gain _____

How do you learn best? (Check all that apply)

( ) Visual- see it ( ) Physical- hands on ( ) Logical- logic/reasoning ( ) Verbal (reading/say it)

List All Medications (or bring a list for a copy to be made)

Name Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

_____

_____

Signature_____ **Date**_____

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Staff Notes

_____

_____

_____

Wt_____ BP _____ HR _____ O2 Sat _____ Heart _____ Lungs _____ Edema _____

Staff Signature _____ Date _____