How did you hear about IVY Cardiac & Vascular Center?
□ Physician Referral
□ Online/Advertisement
□ Family/Friend Referral
□ Other: ______________________________

PATIENT INFORMATION

Date: ______________________ Primary Language Spoken: ______________________

Name: ______________________________ DOB: ____________________ Age: ______

Gender: □Male □Female Race/Ethnicity: □Asian □Black/African American □Hispanic/Latino □ White

Address: ________________________________ City: ______________ Zip Code: ______

Phone Number: ______________________ Email Address: ____________________________

Primary Care Physician: ________________________ Phone Number: ____________________

Referring Physician (if different): ____________________ Phone Number: ____________________

Reason for Visit: ____

Pharmacy: ___________________________ Address: ______________________________

Phone Number: ____________________ Medication Supply Preference: □30 day supply □90 day supply

EMERGENCY CONTACT

Emergency Contact: ________________________ Phone Number: ____________________

Relationship: □Spouse □Child □Parent □Other: ______________________________________

INSURANCE

Primary Insurance: ______________________ Policy#: ____________ Group#: ____________

Subscriber: _________________________________ Subscriber DOB: __________________

Relationship to Subscriber: □Self □Spouse □Child □Other: ______________________________

Secondary Insurance: ____________________ Policy#: ____________ Group#: ____________

Subscriber: _________________________________ Subscriber DOB: __________________

Relationship to Subscriber: □Self □Spouse □Child □Other: ______________________________

Name: ______________________________ DOB: ____________________

Please check all that apply.

MEDICAL HISTORY

- ☐ Anemia
- ☐ Aortic Aneurysm
- ☐ Arrhythmia/Irregular Heartbeat
  - Atrial fibrillation (A. fib)
  - Atrial flutter
  - Bradycardia
  - Supraventricular tachycardia (SVT)
  - Palpitations
  - Ventricular Arrhythmia
- ☐ Asthma/COPD/Emphysema
- ☐ Blood Clots
  - Deep Vein Thrombosis (DVT)
  - Pulmonary Embolism (PE)
- ☐ Bleeding Disorder
- ☐ CVA/Stroke/TIA
- ☐ Cancer
- ☐ Cardiomyopathy/Heart Failure
- ☐ Carotid Artery Disease
- ☐ Congenital Heart Disease
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Endocarditis
- ☐ GERD
- ☐ GI Bleed
- ☐ Gastrointestinal Ulcer
- ☐ Heart Valve Abnormalities/Heart Murmur
- ☐ Hyperlipidemia/ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Neuropathy
- ☐ Peripheral Vascular Disease
  - Peripheral Artery Disease
  - Venous Disease
  - Varicose Veins
- ☐ Pulmonary Hypertension
- ☐ Renal Artery Stenosis
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Syncope
- ☐ Thyroid Disease
- ☐ Other: ______________________

SURGICAL HISTORY

Procedure	Date	Physician
☐ Cardiac Catheterization	Date: ________	Physician: ________________
☐ Cardioversion	Date: ________	Physician: ________________
☐ Coronary Angioplasty/Stent	Date: ________	Physician: ________________
☐ Coronary Artery Bypass (CABG)	Date: ________	Physician: ________________
☐ ICD Placement	Date: ________	Physician: ________________
☐ Pacemaker Placement	Date: ________	Physician: ________________
☐ Peripheral Vascular Angioplasty/Stent	Date: ________	Physician: ________________
☐ Peripheral Artery Bypass/Endarterectomy	Date: ________	Physician: ________________
☐ Radiofrequency Ablation	Date: ________	Physician: ________________
☐ Heart Valve Repair/Replacement	Date: ________	Physician: ________________
☐ Aneurysm Repair	Date: ________	Physician: ________________
☐ Carotid Surgery	Date: ________	Physician: ________________
☐ Amputation	Date: ________	Physician: ________________
☐ Other: ____________________	Date: ________	Physician: ________________

Name: ____ DOB: ____________________________

SOCIAL HISTORY

Marital Status: □Single □Married □Divorced □Widowed

Occupation: ____________________________

Do you consume alcohol? □Yes □No □Former
Frequency: ________________

Do you smoke/use tobacco? □Yes □No □Former
Number of years: ______________
Packs per day: ________________

Do you use illicit drugs? □Yes □No □Former
Substance type: ___________________

Do you exercise regularly? □Yes □No
If YES, describe: ______________________________

FAMILY HISTORY

Is there any family history of:

Condition	Yes/No	Family Member(s)
□ Myocardial Infarction/Heart Attack	□Yes □No	Family Member(s): ________________
□ Stroke/CVA	□Yes □No	Family Member(s): ________________
□ Coronary Artery Disease	□Yes □No	Family Member(s): ________________
□ Diabetes	□Yes □No	Family Member(s): ________________
□ Hypertension (High Blood Pressure)	□Yes □No	Family Member(s): ________________
□ Sudden Death	□Yes □No	Family Member(s): ________________
□ Hyperlipidemia/High Cholesterol	□Yes □No	Family Member(s): ________________

REVIEW OF SYSTEMS

Symptom	Yes/No	Symptom	Yes/No
Recent weight gain or loss	□Yes □No	Swelling of ankles/feet	□Yes □No
Chest pain, pressure or tightness	□Yes □No	Non-healing sores on legs/feet	□Yes □No
Shortness of breath at rest	□Yes □No	Leg pain/cramps with walking	□Yes □No
Shortness of breath with activity	□Yes □No	Leg pain at rest	□Yes □No
Short of breath lying flat	□Yes □No	Fatigue/malaise	□Yes □No
Cough	□Yes □No	Weakness	□Yes □No
Heart palpitations/heart racing	□Yes □No	Headaches	□Yes □No
Dizziness/vertigo/fainting	□Yes □No	Changes in vision	□Yes □No
Fever/Chills	□Yes □No	Memory loss	□Yes □No

Name: ____ DOB: ____________________________

ALLERGIES

Do you have any allergies to medications, foods, latex, seafood/IV dyes? □Yes □No

If YES, please list:

____ Reaction: ____________________________________

____ Reaction: ____________________________________

____ Reaction: ____________________________________

____ Reaction: ____________________________________

MEDICATIONS

Medication Name	Dose	Frequency