



New Patient Registration Form

Date: _____

Email address: _____

Last Name: _____ First _____ MI _____

Address _____

City _____ State _____ Zip _____

Sex: F _____ M _____ D.O.B _____ Social Security # _____

Home Ph: _____ Work Ph: _____ Cell/other _____

Marital Status: _____ Single _____ Married _____ Divorced / Separated _____ Widowed

If married, Spouse's name _____

Do we have permission to:

Leave a message on your answering machine at home? YES _____ NO _____

Leave a message at your place of employment? YES _____ NO _____

Discuss your medical condition with any member of your household? YES _____ NO _____

If yes, whom? _____ Relationship _____

Emergency Contact:

Name: _____ Relationship _____

Phone: _____ Phone: _____

Address _____ City _____ State _____ Zip _____

Occupation _____

Cardiovascular Specialists seen in the past? Who? _____ When? _____

Referring Physician: _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

Please List Current Physician's you see:

Family/Primary Care: _____ Phone: _____

Pulmonologist: _____ Phone: _____

Nephrologist: _____ Phone: _____

Oncologist: _____ Phone: _____

Dialysis: M T W TH F S Location: _____ Phone: _____

We are required to request the following information. The Federal Administrative Reporting Agency requests that we provide this information for statistical purposes only. Your Participation is optional. Please take a moment to complete the following questions. Thank you.

**If you choose not to participate please initial here: _____

Race: American Indian/ Alaskan Native	Ethnicity: Hispanic / Latino	Preferred Language: English
Native Hawaiian	Not Hispanic or Latino	Spanish
Asian		French
African American/ Black		Creole
Caucasian / White		Other _____

Do you have a living will or other advanced directive? Yes___ NO___

INSURANCE INFORMATION

Do you have Medicare: Yes___ NO___ Is it your primary Insurance Yes_____ NO _____

Do you have Medicaid: Yes___ NO___ Is it your primary Insurance Yes_____ NO _____

Primary Insurance Company_____

Address_____ City_____ State_____ Zip_____

Members Insurance ID# _____ Group # _____

Name of Insured if other than patient _____

Relationship to Patient _____

Insured D.O.B _____ SS# _____

Secondary Insurance Company: _____

Address_____ City_____ State_____ Zip_____

Members Ins. ID# _____ Group # _____

Name of Insured if other than patient _____

Relationship to Patient _____

Insured D.O.B _____ SS# _____

How did you hear about our practice? _____

Print Name: _____

Patient Signature: _____ **Date** _____

******THERE WILL BE A \$25.00 CHARGE FOR ALL INSURANCE /FMLA /DISABILITY PAPERWORK, AND HAVE 20 WORKING DAYS TO COMPLETE. MEDICAL RECORDS WILL HAVE A \$25 FLAT FEE FOR ALL RECORDS RELEASE TO PATIENTS UPON SIGNING A RELEASE AND NO LONGER WITH AHV OFFICE.*****

Medical History

Please check to the right of each item	YES	NO	DON'T KNOW	Please check to the right of each item	YES	NO	DON'T KNOW
Asthma J45.909				HIV Z21			
Aneurysm Z86.79				Irregular Heartbeat I49.9			
Angina I20.9				Kidney Artery Angio/Stent Z95.828			
Shortness of Breath R06.02				Kidney Failure N19			
Artery Clot V12.59				Kidney Stone N20.9			
AFIB 148.91 Aflutter 148.92				Leg or Arm Angioplasty/ Stent Z98.89			
Blood or Clotting disorder V12.3				Leg I82.402 /I82.401 Arm clots I82.609			
Bronchitis J40 Emphysema J43.9				Liver K76.9			
Cancer Type _____ V10.9				Lung Clot Z86.718			
Carotid Stent V43.4				Narcolepsy G47.419			
Chest Pain R07.9				Peptic Ulcer K27.9			
CHF I50.9				P.V.D. I73.9			
CAD I25.10				Prostate N42.9			
Diabetes How long? _____ E11.9				Rheumatic N42.9			
Gallbladder K82.9				Seizures G40.909			
Heart Attack (MI) I21.3				Sleep Apnea G47.30			
Hemodialysis Z99.1				Stomach Artery Angio/Stent Z95.828			
Hepatitis K75.9				Thyroid Disease E07.9			
Hypertension I10				Stroke I63.9 CVA I67.89			
High Cholesterol E83.9				Valvular Heart Disease I35.9			

Allergies

Do you have allergies to drugs, food, latex, dye? ____ Yes ____ No

Allergy –List medication, food, latex, dye, etc.	Reaction – rash, short of breath, hives, itching, etc.

Social History and Lifestyle

Alcohol Use	YES _____	NO _____	Beer ___ Wine ___ Liquor ___
Smoking/ Tobacco Use 305.1	YES _____	NO _____	Number of years ___ Packs per day ___
Profession	Working _____	Retired _____	Unemployed _____
Marital Status	Married _____	Single _____	Divorced _____ Seperated _____
Living Status	Spouse _____	Alone _____	Other _____
Diet	YES _____	NO _____	What Type?
Caffeinated Beverages	YES _____	NO _____	How many daily?
Exercise	YES _____	NO _____	How many days a wk? ___ how long? _____
Substance Abuse	YES _____	NO _____	Type of Drug Dependency?
Military ?			Branch?

Current Medications

List all vitamins, prescription medications, and over-the-counter medications

*****Bring ALL Medications in their original containers to every appointment*****

Medication Name	Dosage	How often do you take?	Prescribing Physician

Past Surgeries & Procedures

Past Surgeries/ Procedures	YES	NO	DON'T KNOW	Past Surgeries/ Procedures	YES	NO	DON'T KNOW
Ankle Z96.669				AICD/ DEFIB Z95.810			
Appendectomy Z90.49				Aortic Aneurysm Repair Z98.89			
Back Z90.10				Cardiac Catheterization Z98.89			
Breast Z98.49				Cardiomyoplasty			
Cataract Z98.49				Cardioversion Z98.89			
Gallbladder Z90.89				Coronary Angioplasty Z98.61			
Gastric Bypass V45.86				Coronary Artery Bypass Z95.1			

Past Surgeries/ Procedures	YES	NO	DON'T KNOW	Past Surgeries/ Procedures	YES	NO	DON'T KNOW
Hernia Z91.49				Coronary Revascularization Z95.1			
Hip Z96.49				EP Study			
Hysterectomy Z90.79				Heart Transplant			
Intestinal Z90.49				Heart Valve Surgery Z94.1			
Knee Z96.659				Homograft Replacement Z95.4			
Lap Band Z98.84				ICD Lead Extraction T827XXA			
Prostate Z98.84				Pacemaker Implant Z95.0			
Sleep Apnea Surgery V90.89				RF Ablation Z98.89			
Tonsils Z90.89 Adenoids Z90.89				Valvuloplasty Z98.89			

Any Family History of Cancer, Diabetes, High Blood Pressure, Heart Disease, Heart Attack...etc..??? Please list any:

**Our cardiovascular specialists have privileges at Baptist Medical Centers, Baptist South, Memorial Hospital Jacksonville, Orange Park Medical Center, Specialty Hospital, Brooks Rehabilitation Hospital, St. Vincent's Medical Center Southside and Flagler Hospital. If you or your family members are admitted to these hospitals, please ask the your nurse or administration for your doctor here at Ashchi Heart & Vascular Center so we may provide you with the continuous excellent care you always enjoyed with our group. We are on call for our patients 24/7 at these locations. Our group provides you with board certified cardiologists and vascular specialists in several First Coast area locations.

Print Name: _____

Signature: _____

Date: _____



_ DR. Majdi ASHCHI _ DR. AHSAN "SONNY" ACHTCHI _ Dr. Jack Salah
_ C. SANTOS, MSN, AGPCNP-BC _ J. KOPSKY, MSN, NP-C _ DR. Simi Kumar

EPWORTH SLEEPINESS SCALE

Date: _____

Patient: _____ DOB: _____

Are you currently using a CPAP? ___ Yes ___ No

Do You have sleep Apnea? ___ Yes ___ No

Rate your sleepiness as: 0 = No chance of dozing
 1 = Slight chance of dozing
 2 = Moderate chance of dozing
 3 = High chance of dozing

How likely are you to doze off or fall asleep in the following situations? Use the sleepiness scale to choose the appropriate number for each situation.

- 1. Sitting and reading _____
- 2. Watching TV _____
- 3. Lying down to rest in the afternoon _____
- 4. Sitting inactive in a public place (watching movie, in a meeting) _____
- 5. As a passenger in a car for an hour without a break _____
- 6. Sitting and talking to someone _____
- 7. Sitting quietly after lunch without alcohol _____
- 8. In a car, while stopped for a few minutes in traffic _____

TOTAL (SUM OF NUMBERS ABOVE)

Total: _____



Sleep Questionnaire

Name: _____ DOB _____

Please check ALL that apply to you:

- Do you snore?
- Have you been told that you stop breathing during sleep?
- Do you wake up gasping for breath?
- Have you been told you often kick and mover your legs during sleep?
- Are you excessively tired during the day?
- Do you have a history of hypertension (high blood pressure)?
- Do you feel tired even when you thought you had a good night of sleep?
- Have you been diagnosed with atrial fibrillation or congestive heart failure?
- Is your neck size greater than 17 inches (male) or greater than 16 inches (female)?
- Do you awaken unrefreshed?
- Do you have a sensation of crawling feelings or discomfort in your legs when trying to sleep?
- Do you have trouble with falling asleep at night?
- Have you been told you talk or walk in your sleep?
- Do you suffer from occasional bedwetting?
- Have you been told that you act our your dreams?
- Do your feel paralyzed when falling asleep or waking up?
- Do your experience sudden weakness when laughing?
- Do you regularly require long naps during the day?
- Do you have uncontrollable daytime sleep attacks?
- Do you find yourself falling asleep during work or school?
- Have you noticed difficulty concentrating during the day?
- Do you find yourself falling asleep while driving?
- Have you notice behavioral difficulties or difficulties at school?
- Do you suffer from teeth grinding during sleep?



Patient Name: _____ DOB: _____

1. Have you had a sleep study before? Yes No
If yes, When? _____ Where? _____ Doctor's name? _____
2. Have you had a sleep study and CPAP before? Yes No
If yes, When? _____ Where? _____ Doctor's name? _____
3. Bed Partner? Yes No If yes, Who? _____
4. How many hours do you sleep a night? _____
Sleep meds or AID? Yes No Type _____ How long _____
5. Alcohol use? Yes No How much _____ What Type _____
If yes, Do you use it to sleep? Yes No
6. Do you use caffeine? Yes No How much _____ What type _____
How long have you been using caffeine? _____
7. Naps? Yes No Duration _____ Describe _____
8. Sleepy while driving? Yes No MVA or Occupational accident due to sleepiness?
Describe _____
9. Insomnia? Yes No Describe _____
10. SDB symptoms? Dry Mouth Frequent arousal Choking/gasping Witnessed apnea
 Sore Throat Morning Headache Unrefreshed in AM Snoring
Describe _____
11. Restless Leg Syndrome symptoms? Yes No Explain: _____
Charlie Horses? Describe _____
12. Narcolepsy symptoms? Cataplexy Sleep Paralysis Hallucinatory imagery
Describe _____
13. RBD symptoms? Dream enactment Sleep Injuries
Describe _____
14. Other symptoms? Parasomnia Sleep talking Groaning
Describe _____