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
Native Hawaiian
Asian
African American/ Black
Caucasian / White

Ethnicity: Hispanic / Latino
Not Hispanic or Latino

Preferred Language: English
Spanish
French
Creole
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_________________

<u>**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.***</u>**

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 120.9				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:

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**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: ____

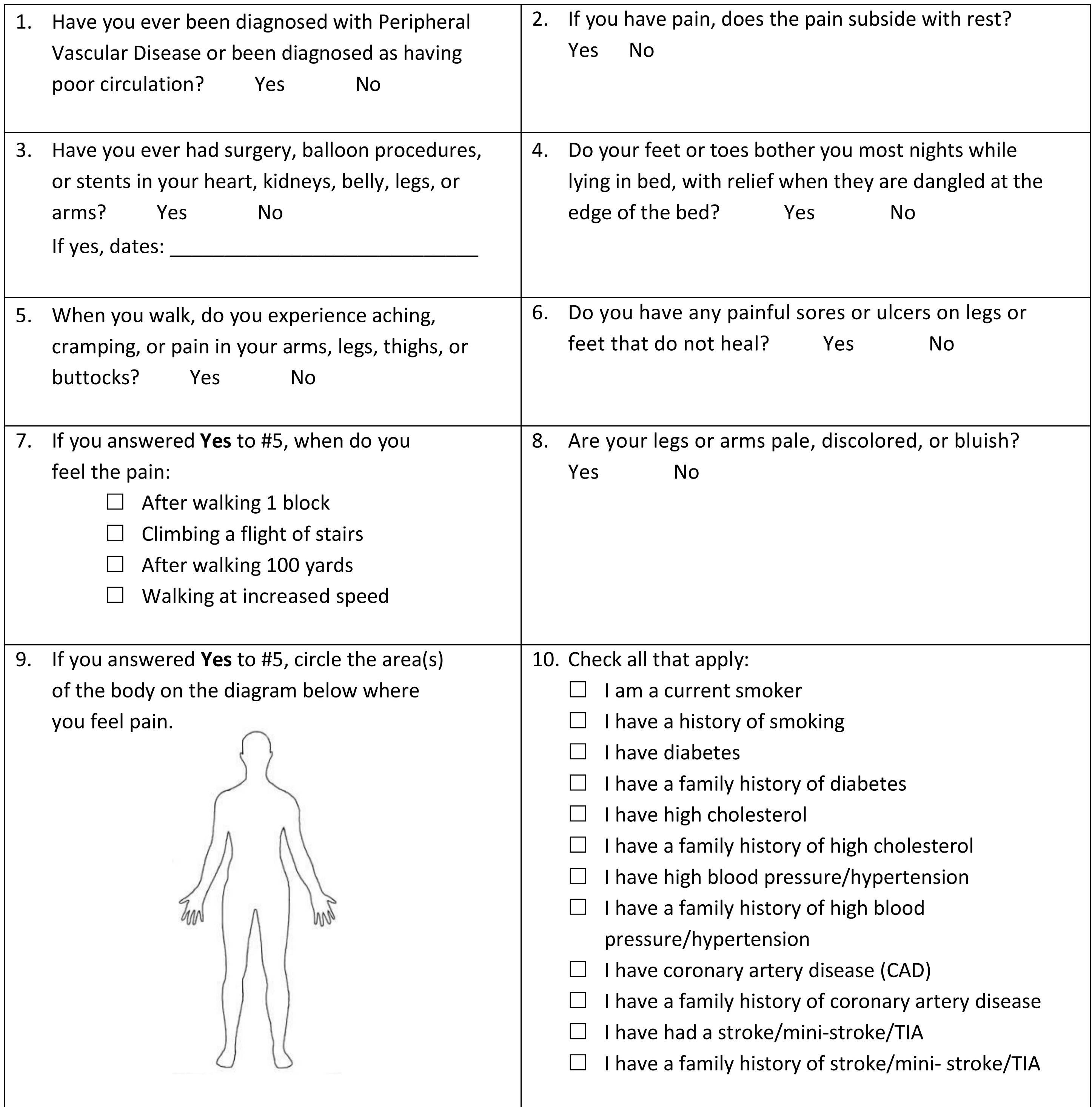
Date: ________________________

ASHCHI HEART & Vascular Center

Peripheral Vascular Disease (PVD) is a common circulatory problem in which vessels carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PVD.

Please circle “Yes” or “No” on the following questions and check all boxes that apply:



1. Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? Yes No	2. If you have pain, does the pain subside with rest? Yes No
3. Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms? Yes No If yes, dates: ______________________________	4. Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? Yes No
5. When you walk, do you experience aching, cramping, or pain in your arms, legs, thighs, or buttocks? Yes No	6. Do you have any painful sores or ulcers on legs or feet that do not heal? Yes No
7. If you answered **Yes** to #5, when do you feel the pain: ☐ After walking 1 block ☐ Climbing a flight of stairs ☐ After walking 100 yards ☐ Walking at increased speed	8. Are your legs or arms pale, discolored, or bluish? Yes No
9. If you answered **Yes** to #5, circle the area(s) of the body on the diagram below where you feel pain.	10. Check all that apply: ☐ I am a current smoker ☐ I have a history of smoking ☐ I have diabetes ☐ I have a family history of diabetes ☐ I have high cholesterol ☐ I have a family history of high cholesterol ☐ I have high blood pressure/hypertension ☐ I have a family history of high blood pressure/hypertension ☐ I have coronary artery disease (CAD) ☐ I have a family history of coronary artery disease ☐ I have had a stroke/mini-stroke/TIA ☐ I have a family history of stroke/mini- stroke/TIA

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____