CARDIOVASCULAR CONSULTANTS

Date: _____

2600 6th St. SW, Suite A2-710 * Canton, OH 44710 *(330) 454-8076 * 1-800- 654-8076

Additional locations in North Canton, Dover, Massillon, Alliance, Carrollton, Millersburg and Salem

Please MAIL back to the office as Soon as Possible

CONFIDENTIAL INFORMATION FORM

Please print or type. If you do not understand the question, leave it blank.

Bring all medications you are currently taking and your most updated insurance card with you the day of your appointment.

Patient Name: _____ Date Of Birth: _____

Age: _____ Sex: _____ Social Security Number: _____

Address: _____
STREET AND PO BOX CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____ Spouse's Name:_____ Date of birth _____

Single: _____ Divorced: _____ Widowed: _____ Married: _____

Race: _____ Ethnic Background: _____ Preferred Language: _____

Education: _____ Yrs. Elementary _____ Yrs. High School _____ Yrs. College, Technical, Etc.

Employment status: ____ Full time ___Part time _____Retired ____Self employed ___ Student

OCCUPATION & COMPANY NAME**:** _____

Family Doctor _____Referring Physician: _____

Do you give us permission to acquire your medication history electronically? ____Yes ____ No

What is the best way to contact you: Phone_____ Postal Mail ____or Email _____
PLEASE CHECK ONE CHOICE ABOVE

How did you hear about our practice? Please select all that apply:

- ☐ Physician Referral
- ☐ Billboard
- ☐ Event/Health Fair
- ☐ Other _____
- ☐ Internet Advertising
- ☐ Direct Mail / Postcard
- ☐ Word of Mouth
- ☐ Print Advertising
- ☐ Facebook
- ☐ Google/online search

I, _____ give my consent to Cardiovascular Consultants to discuss my current and past medical condition with the following people. Signed: _____

Emergency Contact: _____Phone No.: _____Relationship: _____

Name	Phone Number	Relationship to Patient

REASON FOR VISIT (Please state in your own words):

_____

_____

MEDICATION (Please attached another paper if needed). Include all prescription and over the counter medications

Medication Name	Dosage	Frequency	Reason

ALLERGIES: _____

DIAGNOSTIC STUDIES (Please supply date of last test):

Cardiovascular Stress Test	Date:	Chest X-Ray	Date:
CT Scan	Date:	Echocardiogram	Date:
Heart Catheterization	Date:	Muga	Date:
Carotid Ultrasound	Date:	EKG	Date:
Holter or Event Monitor	Date:	Colonoscopy	Date:
Labwork	Date:	Mammogram	Date:
Flu Vaccine	Date:	Pneumonia Vaccine	Date:

Are you currently wearing an Event Monitor or Holter? _____ yes _____no If yes who ordered_____

PAST MEDICAL HISTORY (Please check all that apply):

Anemia		Coronary Artery Disease		Hypothyroidism	
Angina Pectoris		Depression		Migraine Headache	
Arrhythmia		Diabetes Mellitus, Type I		Murmur	
Arthritis		Diabetes Mellitus, Type II		Myocardial Infarction	
Asthma		DVT		Palpitations	
Atrial Fibrillation		Fibromyalgia		Peripheral Vascular Disease	
Cancer		Gastroesophageal Reflux Disease		PVC's	
Cardiomyopathy		Glaucoma		Rheumatic Heart Disease	
Carotid Artery Disease		Heart Block		Seizure Disorder	
Cerebrovascular Accident (Stroke)		Hepatitis		Sleep Apnea	
Chronic Ischemic Heart Disease		HIV-Positive		Syncope	
Chronic Kidney Disease		Hypercholesterolemia		Ulcer Disease	
Congestive Heart Failure		Hypertension		Valvular Heart Disease	
COPD		Hyperthyroidism			

Other:

SURGICAL HISTORY (Have you had any of the following surgeries?)

Surgery:	Year:	Surgery:	Year:
Abdominal Aortic Aneurysm Repair		Heart Valve Surgery	
Amputation		Hernia Repair	
Aorta-iliac-Femoral Bypass		Hysterectomy	
Appendectomy		Internal Cardiac Defibrillator	
Arthroscopic Knee Surgery (Left)		Laminectomy	
Arthroscopic Knee Surgery (Right)		Lumpectomy	
Atrial Septal Defect Repair		Mastectomy	
Brain Surgery		Melanoma Excision	
Cardiac Pacemaker Insertion		Nephrectomy	
Cardioversion		Peripheral Vascular Angioplasty/Stent	
Cataract Removal		Prostatectomy	
Cholecystectomy (gallbladder)		Pulmonary Vein Antrum Isolation (PVAI)	
Coronary Angioplasty/Stent		Radio Frequency Ablation	
Coronary Artery Bypass Graft		Spinal Surgery	
Defibrillator Implant		Splenectomy	
Endarterectomy		Thyroidectomy	
Gastric Bypass		Tonsillectomy	
Heart Catheterization		Transplant	

Other:

FAMILY HISTORY (Has a close relative ever been diagnosed with any of the following?):

ILLNESS:	RELATIVE (Mom, Dad, Sibling,etc.):	ILLNESS:	RELATIVE (Mom, Dad, Sibling,etc.):
Cancer		Hypertension	
Congestive Heart Failure		Ischemic Heart Disease	
Coronary Artery Disease		Myocardial Infarction	
CVA (stroke)		Respiratory Condition	
Diabetes Mellitus		Sudden Cardiac Death	
Heart Disease		Family History Unknown	
Hypercholesterolemia			

Other: _____

_____

SOCIAL HISTORY:

Do you exercise? _____ No _____ Yes How often: _____

Have you ever smoked or used tobacco products? ____ No ____ Yes Do you still smoke or use? ____No _____ Yes

What type do you smoke or use? *(please circle one)* Cigarettes Cigars Pipe Chew Snuff

How long have you been smoking/using? _____ Yrs. How much per day: _____

When did you quit smoking/ using tobacco products: _____

Do you use recreational drugs? _____ No _____ Yes How often: _____Type of substance_____

Do you consume alcohol: ___No _____Yes How much alcohol do you consume weekly: _____

How much caffeine do you consume daily? _____

Local Pharmacy:

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

Mail Order Pharmacy:

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

Sandeep Anreddy, MD * Gregory J. Bonavita, MD,FACC * Stephen M. Denning, MD * Milan R. Dopirak, MD,FACC * Brendan Duffy, MD, FACC* Jason P. Evanchan, D.O.* Carlos E. Fabre, MD,FACC*Ira R. Friedlander, MD,FACC * Nagapradeep Nagajothi, MD * Kavitha Nidamanuri, MD * John J. Paulowski, MD, FACC * Ramana Podugu, MD, FACC * John Prodafikas, MD, FACC* Patricia J. Rubin, MD, FACC * Donald L. Russell, MD * S. Dinakar Satti, MD,FACC * Akbar Shah, MD,FACC * Adnan R. Zaidi, MD,FACC