

Patient Questionnaire

Name: _____

Date: _____

Referring physician: _____

Your Medical History: (Check each one that applies)

- | | |
|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney / Bladder Disease |
| <input type="checkbox"/> Gastro esophageal Reflux | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> AIDS or HIV + |
| <input type="checkbox"/> Asthma/Pneumonia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Abnormal Heart Valve requiring antibiotics when visiting the dentist | |
| <input type="checkbox"/> Hepatitis A / Hepatitis B / Hepatitis C | |
| <input type="checkbox"/> Psychological problems / Clinical Depression | |
| <input type="checkbox"/> Glaucoma | |

LIST MAJOR ILLNESSES & SURGERIES YOU HAVE HAD:

MEDICATIONS YOU ARE CURRENTLY TAKING:

ALLERGIES:

DO YOU HAVE A HISTORY OF SMOKING: ____ Yes ____ No # _____ pks/day/# _____ yrs

DO YOU HAVE A HISTORY OF ALCOHOL USE: ____ Yes ____ No SPECIFY _____

OF DRINKS _____ DAY _____ WK

DO YOU USE DRUGS FOR RECREATIONAL PURPOSES: ____ YES ____ NO

Patient Contact information

Persons who are involved in your care (family, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note that in emergency situations we may share information with others who are not specifically listed on this form)

Please list those persons (including family, friends, previous treating physicians, and other doctors/specialists) with whom we may share your information:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is the best number for us to contact you? _____

From time to time we will leave a message for you on an answering machine, voicemail, or another individual in your absence. Is it OKAY for such a message to include details (such as diagnosis and medication information) at this number? YES NO

Please list all other numbers by which we may reach you:

Home: _____ Is it okay to leave a detailed message at this number? _____

Work: _____ Is it okay to leave a detailed message at this number? _____

Cell: _____ Is it okay to leave a detailed message at this number? _____

Other: _____ Is it okay to leave a detailed message at this number? _____

Signature of Patient or Legal Representative

Date

Print Patient Name or Legal Representative

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

The Heart Center
290 East Medical Center Blvd.
Webster, TX 77598
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