YUMA CARDIOLOGY ASSOCIATES / PATIENT REGISTRATION FORM

Today's Date:		Patient's Primary Care Physician or Clinic Name	

PATIENT INFORMATION

Please Print

Patient's Last Name	Patient's First Name	Middle Initial	Mr. ___ Mrs. ___	Miss ___ Ms. ___	Patient's Marital Status (Circle One): Single	Married	Divorced	Separated	Widowed

Is this Patient's legal name? Yes	No	If no, legal name:	Former Name(s) (please list all)	Patient's Birth Date: Mo.	Day	Year	Age:	Patient's Sex (Circle One): Male	Female

Patient's Street Address:	Social Security No.	Primary Phone ( )	Secondary Phone ( )

P.O. Box:	City:	State:	Zip Code:

Patient's Occupation:	Employed by:	Employer Phone ( )

Patient chose clinic because /Patient was referred to Clinic by *Please select one or fill in here:*	Clinic/Doctor	Insurance Plan	Hospital

PATIENT PREFERENCES

Please Print

Communication Preference: (Circle One) MyCare *Patient Portal*	Email *Please provide email address*	Mail *Will send to Patient's Address above*	Preferred Primary Language:	Interpreter Needed: Yes	No	Preferred Pharmacy Name:	Preferred Pharmacy Location *(Please be as specific as possible):*
Email Address:							

(Optional) Ethnicity:		(Optional) Religious Preference:	

PAYMENT & INSURANCE INFORMATION

Please Print

Person Responsible for Bill (*Guarantor*):	Birth Date: Mo.	Day	Year	Address (if different from Patient):	Home Phone No: ( )

Is this person a patient here? *(Circle one)* Yes	No	Occupation:	Employed by:	Employer Address:	Employer Phone No. ( )

PRIMARY INSURANCE If Applicable

Please provide your insurance card to the receptionist

Patient's **PRIMARY Insurance** Name:	Group Number:	Policy Number:	Co-Payment:

Who provides insurance? (Subscriber):	Subscriber's Social Security No.	Subscriber's Birth Date: Mo.	Day	Year

Patient relationship to subscriber (circle one):	Self	Spouse	Child	Other

SECONDARY INSURANCE If Applicable

Please provide your insurance card to the receptionist

Patient's **SECONDARY Insurance** Name:	Group Number:	Policy Number:	Co-Payment:

Who provides insurance? (Subscriber):	Subscriber's Social Security No.	Subscriber's Birth Date: Mo.	Day	Year

Patient relationship to subscriber (circle one):	Self	Spouse	Child	Other

EMERGENCY CONTACT Information

Please Print

Name of Local Friend or Relative:	Relationship to Patient:	Primary Phone No. ( )	Secondary Phone No. ( )
Name of Local Friend or Relative:	Relationship to Patient:	Primary Phone No. ( )	Secondary Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Yuma Cardiology Associates or insurance company to release any information required to process my claims.

Patient / Guardian Signature:	Date:

Updated 9/29/2016

YUMA CARDIOLOGY ASSOCIATES, P.C.

CONFIDENTIAL MEDICAL HISTORY

Patient Name: _____

Record #: _____

Name: _____ Age: _____ Date: _____

Referred by (if any) _____

*Please answer **all** questions. If you do not know the answer, or do not understand the question, insert a question mark in the space*
Please leave no blanks.

CHIEF COMPLAINT

List the problems which have led you to seek medical help now and approximately when each began:

	Problem	Date of Onset
1		
2		
3		
4		
5		

GENERAL HEALTH AND HABITS

Characterize your present health status: Excellent ( ) Very Good ( ) Average ( ) Poor ( )

Exercise

Do you exercise regularly? Yes ( ) No ( )
How long have you exercised on a regular basis? ..... yrs.
Type of exercise(s) .....
How often ..... days/week ..... minutes each time

Smoking

Do you smoke? Yes ( ) No ( )
How many per day ..... For how many years .....
What do you smoke? Cigarettes ( ) Pipe ( )
Cigars ( ) Other (specify) .....
When did you quit smoking? ..... years ago
How long have (had) you smoked? ..... years

Nutrition

Are there foods you avoid (or limit) for health reasons?
Specify: .....

Alcohol/Beverages

Estimate the amount of alcohol you drink regularly:
..... drinks* per day ..... drinks per week
Did you formerly drink alcohol but have permanently stopped?
Yes ( ) No ( )

Estimate the amount of caffeinated beverages (coffee, tea, cola) you drink per day ..... glasses, cups, or cans

*one drink = 1 can beer, 4 oz. wine, or 1 oz. hard liquor

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgery you have had, indicating the nature of each operation and where and when it was done. (Be accurate and complete. Consult family, friends, physicians, etc.)

Operation	Hospital and City	Date

Have you ever been seriously injured? (If so, give details and date.) _____

List chronologically all hospitalizations not already mentioned. (Do not include childbirth.)

Operation	Hospital and City	Date

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

	NO	YES ? date of onset
RESPIRATORY		
Have you ever had any of the following? (If so, indicate when)		
Pneumonia		
Severe bronchitis		
Pleurisy		
Tuberculosis skin test (Pos or Neg)		
Tuberculosis (infection or contact)		
Asthma (wheezing)		
Chronic bronchitis		
Emphysema		
Other lung trouble		
Exposure to dangerous dust or fumes		
Trouble breathing		
Excessive snoring		
Do you have chest pain?		
Abnormal chest x-ray?		
Have you ever coughed up blood?		
Do you often or regularly:		
Cough?		
Raise sputum?		
Do you often get chest colds?		
CIRCULATORY		
Have you ever had any of the following? (If so, indicate when.)		
Chest pain		
Heart trouble		
Heart attack (coronary)		
Angina pectoria		
High cholesterol		
High blood pressure		
Blackouts		
Racing of heart		
Rheumatic fever		
Heart failure		
Abnormal electrocardiogram		
Swelling of your ankles		
Have you ever taken heart or water pills?		
ENDOCRINOLOGY		
Have you ever had any of the following? (If so, indicate when.)		
Hormone problems		
Thyroid disease		
Diabetes		

PHYSICIAN'S COMMENT
(Leave Blank)

	NO	YES ? date of onset
DIGESTIVE		
Do you often or regularly have:		
Poor appetite		
Trouble swallowing		
"Heartburn"		
Regurgitation of food or bile		
Nausea or vomiting		
Abdominal pain		
Constipation		
Diarrhea		
Has there been any change in your bowel function in the last 6 mos?		
Have you ever had any of the following? (If so, indicate when.)		
Hiatal or esophageal hernia		
Duodenal or gastric ulcer		
Vomiting of blood		
Black or tarry stools		
Blood in your stool		
Yellow jaundice		
Liver trouble or hepatitis		
Gallbladder trouble or stones		
Persistent diarrhea or colitis		
Diverticulitis		
Parasitic infection		
Hernia		
Other digestive disease		
JOINTS		
Have you ever had any of the following? (If so, indicate when.)		
Back pain		
Joint pain		
Joint swelling		
Gout		
Has your doctor diagnosed arthritis. rheumatism?		

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANK

	NO	YES ? date of onset
URINARY		
Have you ever had or been told you had any of the following? (If so, indicate when.)		
Kidney disease or nephritis		
Protein or albumin in urine		
Blood or pus in urine		
Prostate trouble		
Have you ever had a kidney x-ray (I.V.P.)		
HEMATOLOGY & ONCOLOGY		
Have you ever had		
Anemia?		
Bleeding or bruising tendancy?		
Cancer or tumor?		
X-ray or radiation treatment		

PHYSICIAN'S COMMENT
(Leave Blank)

	NO	YES ? dat of onse
NEUROLOGICAL		
Have you ever had any of the following? (If so, indicate when.)		
Neurological disease		
Frequent or recurrent headaches		
Loss of consciousness		
Convulsions or seizures		
Head injury		
Stroke		
Paralysis or muscular weakness		
Tremor or abnormal movements		
Difficulty with coordination		
Difficulty in walking		
Difficulty in speaking		
Double vision or loss of vision		
Numbness		
Dfficulty with memory		
Dizziness		
ALLERGY & IMMUNOLOGY		
Have you ever had		
Asthma?		
Eczema or other skin problems?		
Hay fever or stuffy nose/sinuses?		
A reaction to penicillin?		
A reaction to aspirin?		
A reaction to any other drug? (Specify)		

CURRENT MEDICATIONS

List all the medications you are NOW taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list MUST be detailed, accurate, and complete; therefore consult with your family, druggist, physcian. (Do not neglect aspirin and pain medicines, hormones; contraceptives, water, diet, nerve or sleeping pills.)

Name of Medicine	Strength of each dose	How often taken	When began taking

FAMILY HEALTH

Please give the following information about the health of your immediate family:

RELATION	Age if alive	Age at death	State of health or cause of death
Mother			
Father			
Brothers and Sisters			
Spouse			
Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)

Diabetes _____
Migraine _____
Allergies _____
Alcoholism _____
"Heart Attack" _____

Cancer (Specify type if known) _____
Seizures or epilepsy _____
Blood disease _____
Psychiatric disease or suicide _____
High blood pressure _____

_____
Any obscure or unusual disease _____
Abnormal bleeding or clotting _____
A disease which "runs in the family" _____
Kidney disease _____

Signature of Patient _____