Valley Heart Rhythm Specialists

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New Patient Form

Last Name: _____First Name: _____MI: _____Sex: M__F__

DOB: _____SSN: _____

Home Phone: _____Cell: _____Work: _____

Email Address: _____

Languages Spoken: _____

Home Address: _____

City: _____State: _____Zip Code: _____

Other Home Address: _____

City: _____State: _____Zip Code: _____

Emergency Contact: _____Relation: _____Phone: _____

(Emergency Contact Must Have Different Phone Number than Your Own Phone Number)

Primary Care Physician: _____Phone: _____

Referring Physician: _____Phone: _____

Pharmacy: _____Phone: _____

Address: _____or Cross Roads: _____

City: _____State: _____Zip Code: _____

Primary Insurance: _____ Secondary Insurance: _____

Member ID: _____Member ID: _____

Group: _____Group: _____

Insured Name: _____Insured Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Primary Insured DOB: _____Primary Insured DOB: _____

Patient History

Reason for Visit: _____

Medical History:

Have you ever experienced or been diagnosed with the following?

Heart Attack (Coronary Artery Disease) (Myocardial Infarction)	Yes __ No __ Year Diagnosed _____
Have you had stents placed?	Yes __ No __ When? _____
Have you had bypass surgery?	Yes __ No __ When? _____
Congestive Heart Failure	Yes __ No __ Year Diagnosed _____
Heart Valve Disease	Yes __ No __ Year Diagnosed _____
Have you had surgery for this illness?	Yes __ No __ When? _____
Heart Arrhythmia	Yes __ No __ Year Diagnosed _____
Have you had ablation/procedure for this illness?	Yes __ No __ When? _____
Stroke	Yes __ No __ Year Diagnosed _____
Cancer – What type? _____	Yes __ No __ Year Diagnosed _____
Lung Disease	Yes __ No __ Year Diagnosed _____
Thyroid Disease	Yes __ No __ Year Diagnosed _____

Social History:

Occupation: _____Retired: Yes _____ No _____

Employer: _____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widow(er) ___ Life Partner ___

Do you have children? Yes ___ No ___ Number of Children: ____

Do you use tobacco? Yes ___ No ___ Quantity/Day _____Former (Year Quit) _____

Do you consume caffeine regularly? Yes ___ No ___ Quantity/Day _____Type: _____

Do you use alcohol? Yes ___ No ___ Quantity/Day _____Former (Year Quit) _____

Do you use illicit drugs (cocaine, methamphetamine, etc)? Yes ___ No ___ Former (Year Quit) _____

Do you exercise regularly? Yes ___ No ___ Times/Week _____ Type: _____

Family History:

Premature Coronary Artery Disease (Heart Attack) Yes ___ No ___ Relation: _____

(Diagnosed before age 55)

Diabetes Yes ___ No ___ Relation: _____

High Blood Pressure Yes ___ No ___ Relation: _____

High Cholesterol Yes ___ No ___ Relation: _____

Peripheral Vascular Disease Yes ___ No ___ Relation: _____

Other Health Problem _____ Relation: _____

Allergies:

Are you allergic to any medication? Yes ___ No ___

Medication	Reaction (s)
_____	_____
_____	_____
_____	_____

Do you have any other allergies? (foods, tape, iodine, etc …)

_____

List of Current Medications:

Medications	Dosage	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____