

Your Appointment is Scheduled for:

<i>DAY</i>	<i>TIME</i>
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CANCELLATION POLICY

Please inform us at least 72 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients. Please note that we reserve two hours of time with our staff for your appointment, so late cancellations significantly affect us.

Patients who cancel or reschedule less than 72 hours prior to their appointment will be charged a \$200 cancellation fee.

Please contact our office if you have any questions.

APPOINTMENT PREPARATION INSTRUCTIONS

1) Fasting

- Please refrain from eating for eight (8) hours prior to your visit
- Please DO drink water, but avoid all other beverages
- You may take medications with water
- Please refrain from consuming alcohol for 24 hours prior to your visit
- You are welcome to bring a snack to eat after the fasting portions of your tests have been completed. We will have healthy snacks and drinks on hand for you.

2) Clothing

Because your visit includes an EKG, you should wear appropriate clothing.

3) Medical History

Please fill out as much of the Patient Medical History Form as possible prior to your appointment. Some of the questions regarding family history are critical for formulating an accurate “risk score” and providing a comprehensive medical evaluation, and may require inquiry or research. Our staff will assist you in filling out information you have questions about.

PATIENT MEDICAL HISTORY

Please complete this form and bring it with you to your appointment. If you have questions or need assistance, we will review this form with you during your visit.

A detailed family medical history will help our medical providers interpret the history of disease in your family and identify patterns that may be relevant to your own health. This form is needed to assess your risk of certain diseases, determine which diagnostic tests to order as well as type and frequency of screening tests, identify a condition that might not otherwise be considered, and assess your risk of passing a condition on to your children.

1) Demographics

Name			Date of Birth / /	
Address			Gender	
City	State	Zip	Email address (kept confidential)	
Phone #1 ()				
Phone #2 ()			<input type="checkbox"/> Check here if you do NOT want email communication	

2) Social History

Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other:
Living	<input type="checkbox"/> Alone	<input type="checkbox"/> Spouse/Partner	<input type="checkbox"/> Relative	<input type="checkbox"/> Children	<input type="checkbox"/> Other:
Heritage	<input type="checkbox"/> Asian	<input type="checkbox"/> African American	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other:
Occupation:			Job Title/Description:		
Exercise: Do you get 30 min. of steady physical exertion/exercise 3-4 times per week?				<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Walking		<input type="checkbox"/> Running	<input type="checkbox"/> Jogging	<input type="checkbox"/> Swimming	
<input type="checkbox"/> Biking		<input type="checkbox"/> Household Chores	<input type="checkbox"/> Yard Work	<input type="checkbox"/> Other	
Do you have physical conditions that limit your ability to exercise?				<input type="checkbox"/> Y	<input type="checkbox"/> N Specify:
Tobacco Use:	<input type="checkbox"/> Never Used Tobacco	<input type="checkbox"/> Cigarettes	# Per Day	# Of Years	
	<input type="checkbox"/> Ex-Tobacco User	<input type="checkbox"/> Cigars	# Per Day	# Of Years	
	<input type="checkbox"/> Currently Use	<input type="checkbox"/> Pipe	# Per Day	# Of Years	
Alcohol Use:	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, indicate on average how much and check day, week or month			
_____ Beers per:		<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	
_____ Glasses of wine per:		<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	
_____ Mixed drinks per:		<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	
Family History: Has any blood relative of yours had a heart attack or stroke before the age of 60?					<input type="checkbox"/> Y <input type="checkbox"/> N
Personal History: Have you ever had a heart attack, stroke, stent, cath lab procedure involving your heart?					<input type="checkbox"/> Y <input type="checkbox"/> N

Name: _____ DOB: _____ Date: _____

3) Personal History - 1

Check any of the conditions that you currently have or have had in the past

Please explain if the answer is yes

Cardiovascular

High blood pressure ☐Y☐N

High cholesterol ☐Y☐N

Diabetes ☐Y☐N

Heart failure ☐Y☐N

Heart murmur ☐Y☐N

Chest pain or Angina ☐Y☐N

Heart skips a beat ☐Y☐N

Heart beats too fast ☐Y☐N

Passing out spells ☐Y☐N

Rheumatic fever ☐Y☐N

Feet, ankle or leg swelling ☐Y☐N

Short of breath at rest ☐Y☐N

Short of breath with exercise ☐Y☐N

Short of breath lying down ☐Y☐N

Problems sleeping ☐Y☐N

Sexual dysfunction ☐Y☐N

Frequent urination ☐Y☐N

Abdominal pain ☐Y☐N

Genitourinary

Burning or painful urination ☐Y☐N

Blood in urine ☐Y☐N

Bladder infections ☐Y☐N

Incontinence, dribbling ☐Y☐N

Kidney stones ☐Y☐N

Irregular menses (female only) ☐Y☐N

Ears, Nose, Mouth

Loss of smell ☐Y☐N

Nose bleeds ☐Y☐N

Sinus problems ☐Y☐N

Runny nose ☐Y☐N

Postnasal drip ☐Y☐N

Earache or drainage ☐Y☐N

Hearing loss ☐Y☐N

Ringing in ears ☐Y☐N

Sores in mouth ☐Y☐N

Endocrine

Night sweats ☐Y☐N

Excessive thirst ☐Y☐N

Gastrointestinal

Rectal bleeding ☐Y☐N

Blood in stool ☐Y☐N

Loss of appetite ☐Y☐N

Heartburn or indigestion ☐Y☐N

Black or tarry stools ☐Y☐N

Frequent diarrhea ☐Y☐N

Difficulty Swallowing ☐Y☐N

Nausea or vomiting ☐Y☐N

Vomiting of blood ☐Y☐N

Chronic constipation ☐Y☐N

Stomach ulcer ☐Y☐N

Name: _____ DOB: _____ Date: _____

3) Personal History - 2

Check any of the conditions that you currently have or have had in the past

Please explain if the answer is yes

Head and neck

Swelling in neck ☐Y☐NProlonged hoarseness ☐Y☐NFrequent sore throat ☐Y☐NPain or stiffness in neck ☐Y☐N

Musculoskeletal

Swollen or red joints ☐Y☐NPoor leg circulation ☐Y☐NArm or leg weakness ☐Y☐NLeg cramps ☐Y☐NDifficulty in walking ☐Y☐NArthritis ☐Y☐NInflammatory Disease (psoriasis) ☐Y☐N

Skin

Rash, dryness, itching ☐Y☐NChange in nails or skin color ☐Y☐NBleeding, bruising tendencies ☐Y☐N

Psychiatric

Depression ☐Y☐NAnxiety ☐Y☐NNervous breakdown ☐Y☐NAlcohol problems ☐Y☐NPhysical, verbal, sexual abuse ☐Y☐N

Eyes

Glasses or contacts ☐Y☐NDouble, failing vision ☐Y☐NDry eyes ☐Y☐NPain or light sensitivity ☐Y☐N

Neurologic

Light headed or dizziness ☐Y☐NSpeech disturbances ☐Y☐NConvulsions or seizures ☐Y☐NNumbness or tingling ☐Y☐NFrequent headaches ☐Y☐NMemory loss ☐Y☐NParalysis or weakness ☐Y☐N

Lungs

Cough with sputum or blood ☐Y☐NWheezing ☐Y☐NAsthma ☐Y☐N

Misc.

Fever or chills ☐Y☐NRecent weight change ☐Y☐NFatigue ☐Y☐NHeat or cold intolerance ☐Y☐NRecent changes in mood ☐Y☐N*Please include any other conditions you would like to discuss with the medical provider:*

Name: _____ DOB: _____ Date: _____

4) Weight / Dieting History

Do you want to change your eating habits?

☐Y ☐N Why? _____

Have you tried to lose weight before?

☐Y ☐N How many times? _____

Are you currently on a special diet?

☐Y ☐N Specify _____

Have you used any diet programs in the past?

☐Y ☐N Which ones? _____

What was your weight at age 20? (in pounds)

Are members of your family overweight?

Explain _____

Fill in the box of the number closest to your best estimate of servings per day

Foods with fat/cholesterol (fried foods, fatty meats, junk food)

☐0☐1☐2☐3☐4 or more

Fruits and vegetables (4 cups cooked, 1 cup raw)

☐0☐1☐2☐3☐4 or more

Caffeine (1 cup coffee, soda etc.)

☐0☐1☐2☐3☐4 or more

Calcium servings (dairy foods, 8oz. milk, yogurt, cheese, ice cream)

☐0☐1☐2☐3☐4 or more

5) Past Surgeries, Procedures & Diagnostic Tests

List past testing, hospital visits & surgeries (for example: stent, cath procedure, heart surgeries, exercise tests, heart scan, MRI, CT scan etc.)

PLEASE DO NOT WRITE "My physician has copies of all tests"

Surgery Type/Diagnostic Test	Current Problem?	Date	Physician or Hospital where procedure took place
Example: Brain surgery	<input type="checkbox"/> Current <input checked="" type="checkbox"/> Past	May 12, 1988, May 1988	Dr. Brainsurgeon, Houston
_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	_____	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	_____	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	_____	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	_____	_____

Comments/Notes: _____

6) Allergies

List allergies & type of reaction. Include medications, food, & seasonal & environmental allergies (for example: animals, latex, smoke, etc.)

☐No Known Allergies or Never have Been Diagnosed with any Allergies

Allergy to	Description of Reaction
Example: Peanut allergy	Hives and Rash
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Name: _____ DOB: _____ Date: _____

7) Past & Current Medical Problems

List all medical problems for which you are currently being treated or have previously been treated
Include all diseases and illnesses you have been told you have or are being treated for

Condition	Current Problem?	Date first diagnosed	Date when resolved or stopped taking medications or stopped being treated for
Example: Psoriasis	<input checked="" type="checkbox"/> Current <input type="checkbox"/> Past	June 14, 1996 or June 2006	N/A or Currently being treated
Diabetes (only if taking medications)	<input type="checkbox"/> Current <input type="checkbox"/> Past		
High Blood Pressure	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Cholesterol	<input type="checkbox"/> Current <input type="checkbox"/> Past		
	<input type="checkbox"/> Current <input type="checkbox"/> Past		
	<input type="checkbox"/> Current <input type="checkbox"/> Past		
	<input type="checkbox"/> Current <input type="checkbox"/> Past		
	<input type="checkbox"/> Current <input type="checkbox"/> Past		

8) Medications

List type and amount of medications you use on a regular basis
Include prescription, over-the-counter, birth control, hormones, vitamins, herbs, nutritional supplements and recreational drugs

Medication	Dosage/Frequency	Reason for taking	Started (Month/Year)
Example: Aspirin	81mg once per day	Prevention	March 2005

Name: _____ DOB: _____ Date: _____

9) Family History

Please complete as much of this section as possible

You can also bring your family history with you and we will enter the information into the chart below for you

Adopted? ☐ Y ☐ N

Medical Condition	Father	Mother	Brother	Sister	Son	Daughter	Grandparents (PGF, PGM, MGF, MGM)	Comments
Indicate approximate age disease first was identified								
High blood pressure	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
High Cholesterol	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Diabetes (type 1 or 2)	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Heart Attack	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Heart Failure	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Heart surgery/stent/balloon	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Angina (heart pain)	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Leg circulation problem	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Failing kidneys	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Stroke	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Smoking	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Dementia/Alzheimer's	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Alcoholism	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Arthritis	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Birth Defects	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Hearing Problems	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Sudden Death	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____
Genetic Diseases	age _____	age _____	age _____	age _____	age _____	age _____	age _____	_____

Age & L=living D=deceased	Father	Mother	Brother	Sister	Son	Daughter	Grandparents
							PGF _____ PGM _____ MGF _____ MGM _____

*PGF = paternal grandfather; PGM = paternal grandmother; MGF = maternal grandfather; MGM = maternal grandmother

Please include any other details related to your family history or concerns you would like to discuss with our providers:

Name: _____ DOB: _____ Date: _____

10) Phase of Life - women only

Check all boxes that apply to you

Date of last menstrual period (LMP) _____

Menopause:

☐ Pre-menopausal

☐ Experiencing menopause

☐ Other, N/A

Please include any other details related to your family history or concerns you would like to discuss with our providers:

11) How Did You Hear About Us?

☐ Physician referral

☐ Radio

☐ Print advertisement

☐ Television

☐ Internet

☐ Word of Mouth

☐ Other _____

Would you like us to send your results to another health care provider?

☐ Y ☐ N

If so, we will need his or her first and last names and complete address:

Provider's name: _____

Clinic name: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Fax: () _____

Patient Signature: _____



We take your health history as being very important. We trust you do too!
Our clinic endeavors to offer the best care available.

Internal Purposes Only

History reviewed by: _____

Name: _____ DOB: _____ Date: _____

SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Chance of dozing

Sitting and reading	<input type="text"/>
Watching TV	<input type="text"/>
Sitting and talking to someone	<input type="text"/>
Sitting quietly after a lunch without alcohol	<input type="text"/>
Sitting, inactive in a public place (e.g. a theatre or a meeting)	<input type="text"/>
As a passenger in a car for an hour without a break	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit	<input type="text"/>
In a car, while stopped for a few minutes in the traffic	<input type="text"/>

TOTAL

0-10 = Normal

10-12 = Borderline

12-24 = Abnormal

Name: _____ DOB: _____ Date: _____

STRESS QUESTIONNAIRE - page 1

	Never	Seldom	Sometimes	Often	Regular
Heart pounding or racing	0	1	2	3	4
Trembling/shaking	0	1	2	3	4
Grinding of teeth (even in your sleep)	0	1	2	3	4
Do not sleep well	0	1	2	3	4
Susceptible to illness	0	1	2	3	4
Stomach pains	0	1	2	3	4
Headaches	0	1	2	3	4
Migraine headaches	0	1	2	3	4
Feeling tired constantly	0	1	2	3	4
Constipation	0	1	2	3	4
Hollow stomach	0	1	2	3	4
Lowered self-confidence	0	1	2	3	4
Loss of appetite	0	1	2	3	4
Excessive sweating (e.g. hands, face, arm pits etc.)	0	1	2	3	4
Sweaty palms	0	1	2	3	4
Listlessness - don't feel like doing stuff	0	1	2	3	4
Forget things	0	1	2	3	4
Absent-minded	0	1	2	3	4
Feeling irritated	0	1	2	3	4
Nauseous	0	1	2	3	4
Considered suicide	0	1	2	3	4
Pessimistic	0	1	2	3	4
Jealous/Envious	0	1	2	3	4
Moody	0	1	2	3	4
Pain in lower back	0	1	2	3	4
Feelings of depression	0	1	2	3	4
Anxiety	0	1	2	3	4
Loss of interest in things	0	1	2	3	4
Sensitive and/or touchy	0	1	2	3	4
Muscle pain	0	1	2	3	4
Indecisive	0	1	2	3	4
Unnecessary/excessive checking of work	0	1	2	3	4
Difficulty with breathing	0	1	2	3	4
Struggle to overcome minor illness (e.g. a cold)	0	1	2	3	4
Suspicious	0	1	2	3	4
Wasting time on irrelevant activities	0	1	2	3	4
Cannot discuss my problems with others	0	1	2	3	4
Hair loss	0	1	2	3	4
Total score:					

Name: _____ DOB: _____ Date: _____

STRESS QUESTIONNAIRE - page 2

	Never	Seldom	Sometimes	Often	Regular
Throat irritations	0	1	2	3	4
Lost sense of humor	0	1	2	3	4
Impaired concentration	0	1	2	3	4
Struggle to lose/gain weight even when following a diet	0	1	2	3	4
Heartburn	0	1	2	3	4
Skin disorders	0	1	2	3	4
Don't take the initiative you used to	0	1	2	3	4
Nightmares	0	1	2	3	4
Dry mouth	0	1	2	3	4
Consumption of energy drinks (e.g. Red Bull, 5-hour energy etc.)	0	1	2	3	4
Diarrhea	0	1	2	3	4
Nervous twitches in face and scalp	0	1	2	3	4
Feelings of inadequacy	0	1	2	3	4
Easily startled/jumpy	0	1	2	3	4
Increased appetite	0	1	2	3	4
Impaired coordination	0	1	2	3	4
Uncertainty	0	1	2	3	4
Become frustrated quickly	0	1	2	3	4
Less involvement with others	0	1	2	3	4
Biting of fingernails	0	1	2	3	4
Reduced motivation	0	1	2	3	4
Increased caffeine intake (coffee, tea, soda etc.)	0	1	2	3	4
Restlessness	0	1	2	3	4
Poor judgement	0	1	2	3	4
Increased smoking	0	1	2	3	4
Feeling out of control	0	1	2	3	4
Confused thoughts	0	1	2	3	4
Increased time sleeping	0	1	2	3	4
Use tranquilizers, sleeping pills	0	1	2	3	4
Wake up tired	0	1	2	3	4
Feeling overwhelmed by demands	0	1	2	3	4
Excessive blinking	0	1	2	3	4
Daydreaming	0	1	2	3	4
Procrastination	0	1	2	3	4
Feeling panicky	0	1	2	3	4
Difficult to identify causes of nonperformance	0	1	2	3	4
Reduced productivity	0	1	2	3	4
Total score:					

SYMPTOM SURVEY

Name: _____ DOB: _____ Date: _____

	Worse ☹	☺ Better
Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood (depression, stress, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Mild	Moderate	Severe
Joint or muscle aches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed mood or anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Declining mental ability / focus / concentration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes / irritability.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased muscle strength.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased libido / desire.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in sexual performance / climax.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid hair loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin changes / dry or wrinkled skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling or bloating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain / unable to lose weight.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Women Only:

Intimacy dryness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes or night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>