

FOLLOW-UP PATIENT FORM- Northside Cardiology P.C.

(To be completed by all patients who have not been seen in over 3 months)

Name _____ DOB _____

Today's date _____ Date of last visit _____

Phone# (home) _____ (work or cell) _____

Email Address _____

Referring or primary care physician _____ phone# _____

Reason for visit _____

List any hospitalizations, surgery or other major illness since last visit

1. _____

2. _____

3. _____

4. _____

Any recent heart tests? Echo (cardiac ultrasound) Stress test CT/MRI
 Nuclear stress test Cath Date performed _____
(Please notify front desk to make sure we have requested copy of these tests)

Current medication	Dosage	Frequency (how often)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current allergy list

Do you have any specific questions for your doctor?

Patient Name _____

Date _____

Please circle all that apply to you:

CONSTITUTIONAL

Good general health lately Yes No
Recent weight change Yes No
Fevers/chills Yes No

RESPIRATORY

Frequent coughing Yes No
Shortness of breath Yes No
Asthma or wheezing Yes No

EYES

Wear glasses/contact lens Yes No
Blurry vision Yes No

ENT

Sinus problems Yes No
Sore throat or voice change Yes No

URINARY

Frequent urination Yes No
Burning or painful urination Yes No
Blood in urine Yes No
Sexual difficulty Yes No

SKIN

Rash or itching Yes No
Varicose veins Yes No

ENDOCRINE

Excessive thirst or urination Yes No
Heat or cold intolerance Yes No

CIRCULATION

Do you have any discomfort or aching in the muscles of your legs, arms, thighs or buttocks when you walk that is relieved by rest? Yes No

Do your legs ever feel fatigued or heavy when walking or are active? Yes No

Do you ever need to stop and rest when walking or have difficulty keeping up with others? Yes No

Do your feet or toes bother you at night? Yes No

Do you have any painful sores or ulcers on your legs or feet that aren't healing? Yes No

Have you experienced TEMPORARY: Loss of vision in one eye? Yes No

Slurred speech? Yes No

Weakness or numbness of an arm or leg on one side of your body? Yes No

Have you had surgery, balloon procedures, or stents to any blood vessels other than your heart? Explain: _____ Yes No

Have you had blockages in your coronary arteries? Yes No

NEUROLOGICAL

Frequent or recurring headaches Yes No
Light headed or dizzy Yes No
Numbness or tingling sensations Yes No

PSYCHIATRIC

Nervousness/anxiety Yes No
Depression Yes No

HEMATOLOGICAL/LYMPHATIC

Easily bruise or bleed Yes No
Anemia Yes No
Swollen glands Yes No
Previous blood transfusions Yes No

GASTROINTESTINAL

Loss of appetite Yes No
Change in bowel movement Yes No
Nausea or vomiting Yes No
Blood in stool Yes No
Stomach pain, indigestion Yes No

MUSCULOSKELETAL

Joint pain Yes No
Muscle pain or cramps Yes No
Back pain Yes No

SLEEP

Difficulty sleeping Yes No
Excessive snoring Yes No
Breathing stops at night Yes No
Excessive daytime fatigue Yes No

**NORTHSIDE CARDIOLOGY, P.C.
PATIENT INFORMATION FORM**

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient's Name: (first- middle- last) _____ Date _____
Mr./Mrs./Ms _____ Date of Birth _____ Age _____
Address _____ Marital Status _____
City _____ State _____ Zip _____ Email Address _____
Home Phone Number _____ Employer _____
Cell Phone Number _____ Address _____
SS# of Patient _____ City _____ State _____ Zip _____
Sex _____ Employer Phone Number _____

Primary Insurance Name _____ Policy # _____
Address _____ Group # _____
_____ Phone # _____
Name of Insured _____ Relationship to Insured _____
DOB of Insured _____ SS# of Insured _____

Secondary Insurance Name _____ Policy # _____
Address _____ Group # _____
_____ Phone # _____
Name of Insured _____ Relationship to Insured _____
DOB of Insured _____ SS# of Insured _____

Pharmacy Information:

Name of Pharmacy: _____
Address: _____

Telephone Number: _____

**NORTHSIDE CARDIOLOGY, P.C.
PATIENT INFORMATION FORM**

PLEASE PRINT AND COMPLETE ALL ENTRIES

Emergency Contact:

Name _____ Phone # _____

Address _____ City/State/Zip _____

Relationship _____

*****Very Important to Fill Out Below*****

Referring Physician _____ **Phone** _____
First Name *Last Name*

Primary Care Physician _____ **Phone** _____
First Name *Last Name*

PREFERRED METHOD OF PAYMENT (check one): Check Cash Credit Card