CENTRAL GEORGIA
HEART & VEIN CENTER

PATIENT DEMOGRAPHIC SHEET

Last name: _____ First name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone #: _____ Cell phone #: _____

Date of Birth: _____ Social Security #: _____

Sex: ◯ Male ◯ Female ◯ Other, please specify: _____

Marital Status: ◯ S ◯ M ◯ D ◯ W Spouse's Name: _____

Employer: _____ Work phone #: _____

Email Address: _____

Emergency Contact:

Name: _____ Phone: _____

Please list who we may release information to:

1. _____ 2. _____

3. _____ 4. _____

Primary Insurance

Company Name: _____

Policy Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Secondary Insurance

Company Name: _____

Policy Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Signature of Patient: _____ Date: _____/_____/_____

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PAST MEDICAL HISTORY

Please fill in the circle for any illnesses that apply to you.

Do you have a history of any of the following:

◯ Heart disease (heart attack, coronary artery disease, angioplasty, stents, bypass surgery)

◯ High blood pressure

◯ High cholesterol

◯ Diabetes

◯ Stroke

◯ Vascular disease (blockages in the legs or neck)

◯ Heart murmur

◯ Mitral valve prolapse

◯ Rheumatic fever

◯ Hypothyroidism (low thyroid)

PAST SURGICAL HISTORY

Date:	Surgery:	Date:	Surgery:

DIAGNOSTIC TESTING

Have you had any of the following tests performed?

	Yes	NO	Date	Where / Ordering physician?
Stress Test				
Echocardiogram (ultrasound of the heart)				
Cardiac Catheterization				
Chest X-ray				

ALLERGIES

1. Are you allergic to any medications? ◯ Yes ◯ No

If yes, please list ALL allergies:_____

_____

2. Are you allergic to Iodine? ◯ Yes ◯ No

SOCIAL HISTORY

1. Please fill in the appropriate circle ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed
2. How many children do you have? _____
3. What is your present occupation? _____
4. Do you use tobacco products? ◯ Yes ◯ No

   If yes, what type? _____

   How often? _____
5. Do you drink alcohol? ◯ Yes ◯ No

   If yes, how often and how much? _____
6. Do you have a history of substance abuse? ◯ Yes ◯ No

FAMILY HISTORY

Is there a family history of any of the following? If yes, please indicate family member and any details.

Heart disease ◯ Yes ◯ No _____

(Heart attack, coronary artery disease, blockages, bypass surgery, angioplasty stents)

High blood pressure ◯ Yes ◯ No _____

Diabetes ◯ Yes ◯ No _____

Stroke ◯ Yes ◯ No _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you had any lab work done recently, or since your last visit? ◯ Yes ◯ No

If yes, where? _____

Have you been admitted to the hospital or been to the ER? ◯ Yes ◯ No

If yes, why, and what hospital? _____

Have you seen your primary doctor or a specialist since your visit? ◯ Yes ◯ No

If yes, why? _____

Provider Name and/or specialty: _____

MEDICATIONS

Please list ALL the medications (both prescription and non-prescription medications) that you are CURRENTLY taking:

For example, do you take medications such as Motrin, Ibuprofen or Advil?

MEDICATION NAME	DOSE	HOW OFTEN

Please list your preferred pharmacy:

Local pharmacy name: _____ Address: _____ Phone:_____

Mail order pharmacy name: _____ Address: _____ Phone: _____

HOSPITALIZATION HISTORY

Please list your most recent hospitalizations:

When: _____

Where: _____

Why: _____

PHYSICIAN HISTORY

Please list the complete name of ALL the physicians that you currently see:

Physician	Phone Number
_____	_____
_____	_____
_____	_____