



# PATIENT'S PERSONAL HISTORY

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Cardiologist: \_\_\_\_\_

Reason for Today's Consultation/Visit: \_\_\_\_\_

## PRESENT ILLNESS

Location of the problem: Chest      Arm      Leg      Abdomen      Back

Other: \_\_\_\_\_

Rate the pain on a Scale of 0 to 10 (0= None, 5= Moderate, 10= Worst) 1 2 3 4 5 6 7 8 9 10

Describe the problem? Dull to Sharp \_\_\_\_\_ Very sharp \_\_\_\_\_ Sharp then leaves \_\_\_\_\_ Constant \_\_\_\_\_

Other: \_\_\_\_\_

When did you notice the problem? Today \_\_\_\_\_ Days ago \_\_\_\_\_ Weeks ago \_\_\_\_\_ Months ago \_\_\_\_\_

How long does the problem last? 30 minutes \_\_\_\_\_ 1 Hour \_\_\_\_\_ Its always there \_\_\_\_\_

What makes the pain better? Moving around \_\_\_\_\_ Standing Up \_\_\_\_\_ Lying \_\_\_\_\_

Other: \_\_\_\_\_

What makes the pain worse? Moving around \_\_\_\_\_ Standing Up \_\_\_\_\_ Lying \_\_\_\_\_

Other: \_\_\_\_\_

Does anything else occur at the same time? YES \_\_\_\_\_ NO \_\_\_\_\_

Rash      Nausea      Headache      Fever

Describe: \_\_\_\_\_

Does the problem interfere with your normal daily activity? YES \_\_\_\_\_ NO \_\_\_\_\_

Explain: \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ lbs

### PAST MEDICAL HISTORY:

High Blood Pressure      N \_\_\_\_\_ Y \_\_\_\_\_

Diabetes      N \_\_\_\_\_ Y \_\_\_\_\_

High Cholesterol      N \_\_\_\_\_ Y \_\_\_\_\_

Rheumatic fever as child      N \_\_\_\_\_ Y \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

### PAST SURGICAL HISTORY:

Coronary Bypass      N \_\_\_\_\_ Y \_\_\_\_\_ Year \_\_\_\_\_

Heart Valve Surgery      N \_\_\_\_\_ Y \_\_\_\_\_ Year \_\_\_\_\_

Pacemaker/Defibrillator      N \_\_\_\_\_ Y \_\_\_\_\_ Year \_\_\_\_\_

Stents/Angioplasty      N \_\_\_\_\_ Y \_\_\_\_\_ Year \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

### Please List Drug Allergies Below:

Drug Name: \_\_\_\_\_ Type of reaction: \_\_\_\_\_  
Severity: Very Mild Mild Moderate Severe

Onset: Childhood Adulthood Unknown

Drug Name: \_\_\_\_\_ Type of reaction: \_\_\_\_\_  
Severity: Very Mild Mild Moderate Severe

Onset: Childhood Adulthood Unknown

Drug Name: \_\_\_\_\_ Type of reaction: \_\_\_\_\_  
Severity: Very Mild Mild Moderate Severe

Onset: Childhood Adulthood Unknown

**FAMILY HISTORY:**

	Age	Sex	Medical Problems	If Deceased...	
				Age at Death	Cause
Father					
Mother					
Brothers/Sisters					

Do you know of any blood relative who has or had: *(Circle and give relationship)*

Stroke: \_\_\_\_\_ Cancer: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_  
 Diabetes: \_\_\_\_\_ Heart Disease: \_\_\_\_\_ High Cholesterol: \_\_\_\_\_

**MEDICATIONS (prescription and non-prescription):**

We highly recommend that you bring in all your pill bottles (including over the counter drugs) to the visit. Otherwise, please list the medications, strength, and number taken below.

	<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Additional medications, please list on the back page.

Vitamins? N \_\_\_\_\_ Y \_\_\_\_\_ Please List \_\_\_\_\_

Herbs (e.g. teas/drinks)? N \_\_\_\_\_ Y \_\_\_\_\_ Please List \_\_\_\_\_

Oral Contraceptives? N \_\_\_\_\_ Y \_\_\_\_\_ Please List \_\_\_\_\_

## SOCIAL HISTORY:

Occupation: \_\_\_\_\_

Where Employed? \_\_\_\_\_

[ ] Retired [ ] Disabled

Tobacco Use: Amount \_\_\_\_\_ How Long? \_\_\_\_\_ Yr. Discontinued \_\_\_\_\_

Alcohol Use: Type \_\_\_\_\_ Quantity \_\_\_\_\_ Frequency \_\_\_\_\_

Illicit Drug Use: Type \_\_\_\_\_ Quantity \_\_\_\_\_ Frequency \_\_\_\_\_

Coffee Use: Amount \_\_\_\_\_ How Long? \_\_\_\_\_ Frequency \_\_\_\_\_

Tea Use: Amount \_\_\_\_\_ How Long? \_\_\_\_\_ Frequency \_\_\_\_\_

Soft Drinks: Amount \_\_\_\_\_ How Long? \_\_\_\_\_ Frequency \_\_\_\_\_

Exercise Regularly? What kind? \_\_\_\_\_ How often? \_\_\_\_\_

Flu Shot? Yes No When Received: (Mo/Yr) \_\_\_\_\_

## REVIEW OF SYSTEMS:

<p style="text-align: center;"><b><u>Constitutional</u></b></p> <p>____ Fever</p> <p>____ Chills</p> <p>____ Significant Weight Change</p> <p>____ Sleeping on More Than one Pillow</p>	<p style="text-align: center;"><b><u>Skin (Integumentary)</u></b></p> <p>____ Rash</p> <p>____ Itch</p>	<p style="text-align: center;"><b><u>Gastrointestinal</u></b></p> <p>____ Abdominal Pain</p> <p>____ Diarrhea/Constipation</p> <p>____ Nausea/Vomiting</p> <p>____ Heartburn</p>
<p style="text-align: center;"><b><u>Cardiovascular/Respiratory</u></b></p> <p>____ Chest Pain</p> <p>____ High Blood Pressure</p> <p>    [ ] Controlled [ ] Uncontrolled</p> <p>____ Varicose Veins</p> <p>____ Swelling in Ankles/Feet</p> <p>____ Wheezing</p> <p>____ Cough</p> <p>____ Shortness of Breath</p> <p>    [ ] With Exertion</p> <p>    [ ] Without Exertion</p>	<p style="text-align: center;"><b><u>Hematological/ Endocrine</u></b></p> <p>____ Thyroid Problem</p> <p>____ Hot Flashes</p> <p>____ Cold Intolerance</p> <p>____ Diabetes</p> <p>____ Blood Clotting Problems</p> <p>____ Unexplained Bruising</p>	<p style="text-align: center;"><b><u>Musculoskeletal</u></b></p> <p>____ Neck Pain</p> <p>____ Back Pain</p> <p>____ Leg/Hip Pain When Walking</p>
	<p style="text-align: center;"><b><u>Neurological/Psychological</u></b></p> <p>____ Syncope</p> <p>____ Dizziness</p> <p>____ Numbness</p> <p>____ Arm/Leg Weakness</p> <p>____ Depression</p> <p>____ Anxiety</p>	

Additional Comments/Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Physician Use Only

### Physical Exam

<b>General Appearance: (constitutional)</b>	Normal appearance NAD
<b>Eyes:</b>	PERRLA sclera non icteric
<b>ENT:</b>	normal appearance no thyromegaly neck with FROM trachea midline
<b>Hematologic/Lymphatic:</b>	no palpable lymphadenopathy
<b>Cardiovascular:</b>	regular rhythm no murmur, gallops, rubs + palpable peripheral pulses no JVD no HJR no peripheral edema no cyanosis
<b>Respiratory:</b>	normal expansion normal palpation normal percussion normal auscultation
<b>Abdominal/Gastrointestinal:</b>	no tenderness or masses normal bowel sounds no organomegally
<b>Musculoskeletal:</b>	normal strength FROM no clubbing
<b>Skin:</b>	no rashes, lesions or ulcers
<b>Neurologic:</b>	alert and oriented normal gait no focal deficit

**Assessment/Plan:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Total Time Spent:** \_\_\_\_\_

\_\_\_\_\_  
physician signature

\_\_\_\_\_  
date

## NEW PATIENT INFORMATION

DATE OF VISIT \_\_\_\_\_

PATIENT'S NAME (PLEASE PRINT)	SS#	MARITAL STATUS	SEX
STREET ADDRESS	CITY AND STATE	ZIP	
BIRTHDATE AND AGE	HOME PHONE	MOBILE PHONE	
EMAIL ADDRESS	WORK PHONE	OTHER NUMBER(S)	
ETHNICITY	PREFERRED LANGUAGE	RACE	
PATIENT'S EMPLOYER	OCCUPATION	DURATION OF EMPLOYMENT	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE	
DRUG ALLERGIES AND REACTION			
SPOUSE OR PARENT NAME	SS#	BIRTHDATE	
EMERGENCY CONTACT NAME	EMERGENCY CONTACT ADDRESS	PHONE	
REFERRED BY	STREET ADDRESS, CITY, STATE	PHONE	
PRIMARY / FAMILY MD	STREET ADDRESS, CITY, STATE	PHONE	

PLEASE READ: PLEASE PROVIDE THE NECESSARY INSURANCE FORMS AND COPIES OF INSURANCE CARDS & PROOF OF ADDRESS TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS

### PRIMARY INSURANCE

### SECONDARY INSURANCE

NAME OF INSURANCE	NAME OF INSURANCE
STREET ADDRESS, CITY STATE, ZIP CODE	STREET ADDRESS, CITY STATE, ZIP CODE
PHONE NUMBER	PHONE NUMBER
POLICY #	POLICY #
GROUP #	GROUP #
NAME OF POLICY HOLDER AND DOB	NAME OF POLICY HOLDER AND DOB
POLICY HOLDER SS#	POLICY HOLDER SS#

**PLEASE PROVIDE  
CARDS TO BE COPIED**

### INSURANCE AUTHORIZATION AND ASSIGNMENT / HIPPA

Initial \_\_\_\_\_ I authorize the release to Medicare / Other Insurance company of such information as may be necessary of the completion of my insurance claims. I hereby authorize payment directly to Cardiac Surgery Associates, S.C. of the expense benefits otherwise payable to me. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information and payment to the insurer or agency shown. I understand that I am financially responsible for the charges made by them for services rendered. I have read this document in its entirety and I fully understand it.

Initial \_\_\_\_\_ I acknowledge that I have received a copy of the Cardiac Surgery Associates Notice of Privacy Practices

Signature \_\_\_\_\_ Date \_\_\_\_\_



**Cardiac Surgery Associates, S.C.**  
**NOTICE OF PRIVACY PRACTICES**

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review it carefully.

**Our Pledge Regarding Your Health Information**

We understand that information about you and your health is personal. We are committed to protecting the privacy of this information. Each time we provide services, we create a record of the care and services you receive. We need this record to provide quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by us, or received by us from you or others.

Our primary responsibility is to safeguard your personal health information. We must also make available this notice of our privacy practices, and we must follow the terms of the notice that is currently in effect. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights of access, amendment, control and other rights concerning the use and disclosure of your health information.

**PLEASE NOTE:** If you are the parent, legal guardian, or personal representative of the patient we are treating, the references herein such as “your personal health information” shall be understood to refer to that patient.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with any of our facilities. This complaint can be filed in writing to our Privacy Officer: Michael Budzynski, Cardiac Surgery Associates, S.C., 2650 Warrenville Rd., Ste 280, Downers Grove, IL 60515. There will be no retaliation for filing a complaint. You can also file a complaint with the Secretary of the Department of Health and Human Services.

---

---

**How We May Use and Disclose Your Health Information**

The following categories describe different ways that we may USE your health information within Cardiac Surgery Associates, S.C. and DISCLOSE your health information to persons and entities outside of Cardiac Surgery Associates, S.C. We have not listed every use or disclosure within the categories, but give some examples for understanding.

**Common Uses and Disclosures Allowed by Law**

**Treatment:** We may use your health information to provide you treatment and services. We may disclose health information about you to others who are involved in your care.

**Payment:** We may use and disclose your health information so the treatment and services you receive at Cardiac Surgery Associates, S.C. may be billed to and payment collected from you, an insurance company or a third party. We may also disclose health information to your insurance plan to obtain prior authorization for treatment and procedures.

**Health Care Operations:** We may use and disclose your health information for health care operations and activities, such as quality assurance, administration, CSA, SC financial and business planning and development; customer service (including investigation of complaints); and certain marketing and fundraising. These uses and disclosures are necessary to operate our health care facility and make sure patients receive quality care.

**Business Associates:** Some services may be provided to our organization through contracts with business associates, such as accountants, consultants; quality assurance reviewers; billing and transcriptions services. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. We require our business associates to sign a contract that states they will appropriately safeguard your information.

**Contacting You About Your Health:** We may use and disclose health information to contact you, such as a reminder about an appointment or other treatment options at Cardiac Surgery Associates, S.C.

**Marketing or Fundraising:** We may contact you as part of a marketing or fundraising effort. We may, for instance, tell you about CSA, S.C. health related products, services or activities that may be of interest.

**Research That Doesn't Involve your Treatment:** When a research study does not involve any treatment, we may disclose your health information to researchers when an Institutional Review Board has established appropriate protocols to ensure that privacy of your health information, and has approved the research.

**Individuals Involved in your Care:** We may disclose health information about you to a friend or family member who is involved in your care, unless you tell us in advance not to do so.

**Other Laws:** At times there may be federal, state or local laws that require us to use or disclose health information in other ways, and we will obey those laws. Additionally, when a state law about protecting your health information gives you more protection than the federal laws, we will follow those.

**Special Situations Which Do Not Require Your Authorization**

The following disclosures of your health information are permitted by law without any oral or written permission from you:

**Organ and Tissue Donation:** If you are an organ donor, we may release health information to organizations that handle organ procurement or transplantation, as necessary to facilitate the donation.

**Military and Veterans:** If you are a member of the armed forces, we may release health information about you as required by military command authorities.

**Worker's Compensation:** We may release health information about you for worker's compensation or similar programs if you have a work related injury.

**Averting a Serious Threat to Health or Safety:** We may use and disclose your health information when necessary to avert a serious threat to you or others. These disclosures would be made only to someone able to intervene.

**Public Health Activities:** We may disclose health information about you for public health activities including:

- \*To prevent or control disease, injury or disability.
- \*To report births and deaths.
- \*To report child abuse or neglect.

\*To report reactions to medications, problems with products or other adverse events.

\*To notify people of recalls or products they may be using.

\*To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

\*To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence.

\*To Disaster Relief agencies (such as the Red Cross) for notification as to your location and condition.

**Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliant with the civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may be required to disclose your health information in response to a court order, administrative order, subpoena, discovery request or other lawful process by someone involved in the dispute.

**Law Enforcement:** We may disclose health information to law enforcement officials for reasons such as:

\*In response to a court order, subpoena, warrant, summons or similar process.

\*To identify or locate a suspect, fugitive, material witness or missing person.

\*About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.

\*About a death we believe may be the result of criminal conduct.

\*About criminal conduct in our facility.

\*In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Home Directors:** We may disclose health information to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral home directors as necessary to carry out their duties.

**National Security and Intelligence Activities:** We may disclose health information about you to authorized federal officials for intelligence, counter intelligence and other national security activities authorized by law.

**Legal Requirement:** We will disclose health information about you without your permission when required to do so by federal, state or local law.

#### **Other Uses and Disclosures with Your Authorization**

Other uses and disclosure of health information not covered by this notice or applicable laws will be made only without your written permission (called "Authorization"). If you give authorization to do so, you may revoke that authorization in writing at any time. Some typical disclosures that require your authorization are as follows:

**Research Involving Your Treatment:** When a research study involves your treatment, we may disclose your health information to researchers only with your authorization. For any such research study, an Institutional Review Board will often have already have established appropriate protocols to ensure the privacy of your health information, and approved the research. You do not have to sign the authorization in order to get treatment from CSA, S.C. But without your authorization, you cannot be part of the research study.

**Drug and Alcohol Abuse, and Mental Health Treatment Disclosures:** We will disclose drug and alcohol abuse and mental health treatment information about you only in accordance with state and federal laws. In general, your authorization is required for such disclosures.

**Disclosures Requested by CSA, S.C.:** We may give you the option of authorization us to use or disclose your health information for specific purposes such as notifying you of future educational events that might benefit you.

---

### **Your Health Information Rights**

You have the following rights concerning your health information:

1. **Request a restriction on certain uses and disclosures of your information.** We are not required by law to agree to your request.
2. **Obtain a copy of this Notice of Patient Privacy Practices upon request.**
3. **Inspect and/or request a copy of your health record.** We may deny your request under very limited circumstances. If denied, you may request that the denial be reviewed by another health care professional chose by our health care team. We will abide by the outcome of that review.
4. **Request an amendment to your health record** if you feel the information is incorrect or incomplete. We may deny your request if: (1) it is not in writing; (2) it does not include a valid reason; (3) the information was not created by or kept by CSA, S.C.; (4) is not information which you would be permitted to access; (5) if the information is accurate and complete; or (6) it would require us to delete information from your health record.
5. **Obtain an accounting of disclosures of your health information.** The accounting will not include the allowed common uses and disclosures, or uses and disclosures that you authorized.
6. **Request communication of your health information by alternative means or locations.**
7. **Revoke your authorization** except to the extent that action has already been taken.
8. **File a complaint about any aspect of our health information practices** to use or to the Department of Health and Human Services of United States. You can complain to us and expect an investigation and explanation by calling or writing our Privacy Officer: Michael Budzynski, Cardiac Surgery Associates, S.C., 2650 Warrenville rd., Suite 280, Downers Grove, IL 60515. You can make a complaint to the Department of Health and Human Services by addressing your written complaint to Secretary Department of Health and Human Services in an email to [OCCRCComplaint@hhs.gov](mailto:OCCRCComplaint@hhs.gov). or to : The office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Voice Phone (312) 886-2359. FAX (312) 886-1807. TDD (312-353-5693).

---

**We Reserve the right to change this notice** and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A copy of the current notice in effect will be available at CSA, S.C.

Effective Date: 10/01/2012