Ohio Heart Group, Inc.

Keeping Your Heart... In the Best of Hands

Patient Personal History Form

(Please answer all of the following questions as accurately as possible)

FULL NAME: _____ **TODAY'S DATE:** _____

FAMILY PHYSICIAN: _____ **DATE OF BIRTH:** _____

REFERRING PHYSICIAN: _____ **AGE:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING EITHER YES OR NO
WHAT RISK FACTORS ARE YOU FACING FOR THE POTENTIAL DEVELOPMENT OF HEART DISEASE?

Do you smoke now? YES NO
If yes, how much and how long? _____

If not, have you smoked in the past? YES NO
If yes, when did you quit? _____

Have you had high blood pressure? YES NO Unknown

Have you had high cholesterol? YES NO Unknown
If yes, how high is it? _____

Do you have high triglycerides? YES NO Unknown
If yes, how high is it? _____

Do you have diabetes? YES NO Unknown

Has anyone in your family had an early heart attack? YES NO Unknown
(Women 65 or younger; Men 55 or younger)

If YES, please state relationship (mother, father, sister, brother, child, etc.)

_____

CHF SYMPTOMS

Have you ever had congestive heart failure?	YES	NO
Do you have unusual shortness of breath?	YES	NO
Do you have to sleep on several pillows to breathe better	YES	NO
Do you wake up at night with shortness of breath	YES	NO
Do you have swelling in the legs or feet?	YES	NO

CARDIAC HISTORY

Have you ever had a heart attack?	YES	NO
Have you had rheumatic fever?	YES	NO
Do you have a heart valve problem?	YES	NO
Do you have a murmur?	YES	NO
Do you have varicose veins?	YES	NO
When was your last chest x-ray? _____		
When was your last EKG? _____		
Do you have episodes of a fast heart rate or irregular heart rate?	YES	NO
Do you have a pacemaker or defibulator?	YES	NO

If yes, what kind/ brand?_____

SOCIAL HISTORY:

Occupation: _____

Marital Status (circle one): Married Widowed Single Divorced Separated

Number of alcoholic beverages in an average week: 0 1-3 4-6 7-9 9 >

Do you use any illegal drugs? YES NO

If yes, what did you use and how long ago? _____

FAMILY HISTORY:

Has your mother, father, brother, sister or children had any of the following: (please check all that apply)

_____Diabetes _____Asthma _____ Cancer _____ High Blood Pressure

_____Stroke

SYSTEMS REVIEW: DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

{(Please check all that apply. If you are unsure, mark the line with a question mark(?)}

General:

_____Unexplained Fever _____Unexplained Weight Gain
_____Unexplained Weakness _____Unexplained Fatigue
_____Unexplained Weight Loss

Eyes:

_____ Blurred Vision _____ Double Vision _____ Blind Spots

Ears, Nose, Mouth and Throat:

_____Difficulty Hearing _____Hoarseness _____ Ringing In Ears

Lungs:

_____Frequent Cough _____ Wheezing _____ Cough up Blood
_____Unusual Snoring

Peripheral Vascular:

Do you develop pain or discomfort in the muscles of either leg when walking? YES NO
Do you have non-healing foot or leg sores? YES NO

Neurologic:

_____ Sudden trouble speaking _____ Sudden weakness in one side of the body
_____ Passing Out _____ Headaches _____Dizziness

GI:

_____ Black bowel movements _____ Blood in stool _____ Change in bowel habits
_____ Constipation _____ Diarrhea _____ Indigestion
_____ Difficulty swallowing _____ Loss of appetite _____ Frequent vomiting
_____ Frequent nausea _____ Heartburn _____Frequent vomiting

GU:

_____Burning with urination _____Blood in urine _____ Frequent urination
_____Cloudy urine _____ Difficulty with urination

Endocrine:

_____Increased thirst _____Intolerance to heat or cold

Musculoskeletal:

_____Joint pain _____Muscle Pain

Skin:

_____ Skin Problems (If yes, please explain) _____

Psychiatric:

_____ Depression _____Anxiety _____ Other Psychiatric Issues

(Please explain other psychiatric Problems)_____

Hematologic/Immunologic:

_____Easy bruising or bleeding _____Chronic infections

For Women Only:

_____Date of your last period _____Are you pregnant? **YES** **NO**

For Men Only: Have you been diagnosed with any prostate problems? **YES** **NO**

PAST MEDICAL HISTORY: {(Please check all that apply. If you are unsure, mark line with a question mark, (?)}

_____Glaucoma _____Cataracts _____ Asthma _____Emphysema
_____Bronchitis _____Pneumonia _____ Stroke _____Seizures
_____Sleep apnea _____Tuberculosis _____ Diabetes _____Ulcer
_____Hepatitis _____Clots in Lungs _____Clots in legs _____Kidney stones
_____Anemia _____Low thyroid _____ High thyroid _____Previous transfusion Gall
_____Bladder problems _____ Refusal to take blood products

PLEASE LIST ANY PREVIOUS MEDICAL PROBLEMS NOT MENTIONED ABOVE: _____

_____

PLEASE LIST ALL PREVIOUS SURGERIES WITH APPROXIMATE DATES: _____

_____

PLEASE LIST ALL YOUR CURRENT MEDICATIONS (INCLUDE DOSAGES):

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
5. _____ Dosage: _____
6. _____ Dosage: _____
7. _____ Dosage: _____
8. _____ Dosage: _____
9. _____ Dosage: _____
10. _____ Dosage: _____
11. _____ Dosage: _____
12. _____ Dosage: _____

PLEASE LIST ANY DRUG ALLERGIES: _____

REACTION: _____

SIGNATURE: _____ **DATE:** _____

Ohio Heart group, Inc,
800 East Broad Street
Columbus, Ohio 43205
Phone: 614-252-8300
Fax: 614-252-6637

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
Effective April 14, 2003

The Health Portability & Accountability Act of 1996 ("HIPAA" is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used; "HIPAA" provides penalties for covered entities that misuse personal health information.

Uses and Disclosures:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating you health, diagnosing medical conditions, and providing treatment.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as from credit card companies that may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of the medical practice of University Cardiology, Inc. For example, information on services received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your written information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified Ohio Heart Group, Inc of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders

Your health information may be used by our staff to contact you to remind you of an appointment or for issues dealing with appointments including scheduling and /or changes.
Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

You have certain rights under the federal privacy standards.
These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Ohio Heart Group, Inc. is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. Ohio Heart Group, Inc. is required to abide by the privacy policies and practices that are outlined in this notice.

As permitted by law, Ohio Heart Group, Inc. reserves the right to amend or modify out privacy policies and practices. These changes in policies and practices may be required by change in federal and state laws and regulations. Upon request, Ohio Heart Group, Inc. will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health Ohio Heart Group, Inc maintains.

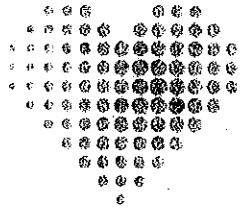
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Official / Practice Administrator
800 East Broad Street Columbus, OH 43205

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the above address. You will not be penalized or otherwise retaliated against for filing a complaint.

For additional information about HIPAA, contact:

The United States Department of Health and Human Services
Office of CMI Rights
200 Independence Avenue, S.W.
Washington DC, 20201
(202) 619-0257



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Ohio Heart Group, Inc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Ohio Heart Group, Inc.

Please Read and fill out completely and accordingly:

May we leave a message at your home with other resident's _____Yes _____No

May we leave a message on your answering machine/voice mail _____Yes _____No

Who may we talk to about your medical concerns / conditions (Name):_____

Relationship to Patient: _____ Phone #: _____

Date of birth:_____

Name of Patient (**print**): _____

Signature of Patient: _____

Date: _____

(If patient is a minor or an adult who is unable to sign this form)

Signature of Patient Representative: _____

Date: _____

Relationship to Patient: _____