HEART CENTER OF NORTH TEXAS, P.A.

CARDIOLOGY

Dear _____

Welcome to the Heart Center of North Texas. Your appointment has been scheduled for _____at_____with Dr. Mott.

Your appointment will be at our Weatherford office located at 920 Hilltop Drive, behind the post office.

Please fill out the following paperwork and bring it with you to your appointment along with your drivers' license or picture ID and your insurance cards. Please do not mail back this paperwork.

If for any reason you are unable to keep this appointment please contact our office at 817-334-2800 and we will gladly reschedule your appointment to a more convenient time.

NOTE: If your insurance requires a referral, you are responsible for notifying your primary doctor so they can obtain one. If we do not receive the referral by your appointment time, you will be rescheduled.

Thank you,

Heart Center of North Texas

PLEASE BRING A LIST OF ALL MEDICATIONS WITH YOU TO YOUR APPOINTMENT

1017 12TH AVENUE
FORT WORTH, TEXAS, 76104
P: 817-334-2800 F: 817-820-0094

920 HILLTOP DRIVE
WEATHERFORD, TEXAS 76086
P: 817-334-2800 F: 817-613-8590

Heart Center of North Texas
Cardiovascular Consultation Clinic

Name: _____ DOB: _____ Sex: _____ Date:_____
Primary Physician:_____
Choose one: Retired/ Disabled/ Occupation:_____

Reason you are being evaluated by a heart specialist?

[]	Discomfort possibly related to your heart	[]	Shortness of breath
[]	Prior heart attack date:	[]	Decreased exercise tolerance
[]	Heart failure	[]	Edema (swelling)
[]	Passing out	[]	Irregular heart rhythm
[]	Abnormal EKG (electrocardiogram)	[]	Stress testing
[]	High blood pressure	[]	High cholesterol
[]	Fast or slow heart rate	[]	Palpitations
[]	Abnormal heart sound or murmur	[]	Prior bypass surgery
[]	Other heart surgery_____	[]	_____

Do you have any risk factors for heart disease listed below?

[]	Past tobacco use (any type)	[]	Current tobacco use
[]	High cholesterol or triglycerides	[]	High blood pressure
[]	Family history of heart disease	[]	Low fat diet
[]	Family history of sudden death	[]	Low activity level
[]	Diabetes (high blood sugars)	[]	High stress lifestyle
[]	Postmenopausal woman [] on estrogen?	[]	Overweight

Please list <u>ALL medical diagnosis/history/problems</u> for which you have been treated. Past and present.

Please list ALL <u>prior surgical procedures</u> you have had.

Have you previously had (approximately when/where/do you know the results)

[] Heart cath/angiogram _____
[] Echocardiogram/Ultrasound _____
[] Stress test _____
[] Nuclear (thallium or cardiolite) _____
[] Rhythm or holter monitor _____
[] Cholesterol check _____
[] Chest X-ray _____
[] EKG _____

What medications do you currently take (include prescription and non-prescription drugs)
****PLEASE BRING ALL YOUR MEDICATIONS OR A CURRENT LIST WITH YOU****

Medication, Dosage ,Etc:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What pharmacy do you use?
Local &/ Mailorder: _
Where:
_ _

Allergies: Medications [] no [] yes _____
_____
_____
Iodine/IV [] no [] yes _____
Foods [] no [] yes _____

Diabetes: [] yes [] no
Type: [] One [] Two **Year Diagnosed:**_____

Marital Status [] Married [] Single [] Divorced [] Widowed
[] Other_____

Children [] None _____x boys _____x girls

Tobacco History [] yes [] no Tobacco Type:_____
[]former packs per day . Do you still smoke_____
years smoked _____ When did you quit _____

Page 3: Name:_____ DOB: _____

Primary Language [] English [] Spanish [] Other_____

Residence, what is your current living arrangements?
[] Assisted living [] With family [] With spouse [] Alone [] Other

Are you on a special diet? [] Regular [] Low fat [] Diabetic
[] Other_____

Are you able to be as active as you want to be? [] yes [] no
If not, why?_____
Do you have any limitations ie: wheelchair, walker_____

Alcohol History [] Never [] Frequent [] Moderate [] Occasional [] Past problem

Drug History [] Never [] Current problem [] Past problem
Drug Type:_____
Quit:_____

Caffeine [] Cokes [] Coffee [] Tea [] Chocolate [] Caffeine pills

Family Medical History:

Mother: [] Heart Disease [] High Blood Pressure [] Stroke [] Diabetes [] Cancer:_____
Other: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Father: [] Heart Disease [] High Blood Pressure [] Stroke [] Diabetes [] Cancer:_____
Other: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Sibling(s): [] Heart Disease [] High Blood Pressure [] Stroke [] Diabetes [] Cancer:_____
Other: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Other Family Member: [] Heart Disease [] High Blood Pressure [] Stroke [] Diabetes
[] Cancer: [] Other:_____

Do you have a living will or advanced directive? [] Yes [] No
Do we have a copy? [] Yes [] No
Does someone else make medical decisions for you? [] Yes [] No

Do you have or recently experienced any of the following:

General:	[] fever [] chills	[] fatigue	[] weight gain [] weight loss
Head:	[] vision problems [] poor teeth	[] hearing problems [] gum disease	
Hematologic:	[] bleeding disorder [] anemia	[] cancer [] easy bruising/bleeding	
	[] Coumadin use: Who follows PT/INR _ _ _ _ _ _ _ _ _ _ Last Time Checked: _ _ _ _ _ _ _ _ _ _ _ _		
Pulmonary:	[] asthma [] cough [] lung cancer	[] blood in sputum [] emphysema [] pneumonia	[] shortness of breath [] history of TB
Cardiac:	[] palpitations [] feet/leg swelling	[] passing out [] Raynaud's	
Gastro:	[] loss of appetite [] nausea/vomiting [] constipation	[] indigestion/reflux [] painful swallowing [] loose stools	[] stomach ulcers [] liver problems/jaundice
Vascular:	[] blue lips/fingers	[] clots in leg veins	[] carotid disease
Genitourinary:	[] painful urination [] blood in urine	[] prostate trouble [] increased frequency/hesitancy	[] urine infections
Extremities:	[] swelling [] arthritis	[] pain in legs [] cramps	
Musculoskeletal:	[] muscles aches [] knee problems	[] back pain [] joint pain	[] disc problems
Neurologic:	[] stroke [] dizziness [] loss of balance	[] numbness [] Alzheimers	[] weakness [] poor weakness
Skin:	[] skin rash	[] change in texture	
Endocrine:	[] thyroid problems	[] low blood sugar	
Psychiatric:	[] depression	[] anxiety	
Other:	[] prior phen fen use []	[] _____ [] _____	[] _____ [] _____