Cardiothoracic and Vascular Surgeons
1010 W. 40th St., Austin, TX 78756
Tel: (512) 459-8753 Fax: (512) 459-0586

Jeffrey M. Apple, M.D.
Phillip J. Church, M.D.
Stephen J. Dewan, M.D.
Emery W. Dilling, M.D.
Mark C. Felger, M.D.
Mazin I. Foteh, M.D.
Kenneth A. Fox, M.D.
Eric M. Hoenicke, M.D.
Brannon R. Hyde, M.D.
Jeffrey S. Jobe, M.D.
Faraz Kerendi, M.D.
William F. Kessler, M.D.
Hunter Q. Kirkland, M.D.
Brian Lima, M.D.
Michael C. Mueller, M.D.
R. Brent New, M.D.
John D. Oswalt, M.D.
John K. Politz, M.D.
Scott A. Seidel, M.D.
Stephen M. Settle, M.D.
Mark T. Stewart, M.D.
Joe K. Wells, III, M.D.

HISTORY AND PHYSICAL CONSULTATION FORM

Date: _____ Patient Name: _____ DOB: _____

Sex: **M / F** (*circle one*) **Ht: _____ft:_____in Wt: _____ lbs BP:_____ / _____ Pulse:_____bpm**

Reason for today's visit: _____

_____

Medication ALLERGIES: *OR* ❑ **NONE (***no allergies)*

Medication	Reaction you have
1.	
2.	
3.	

MEDICATIONS you currently take: *OR* ❑ **NONE (***check box if you take no meds)*

Medication	Dose	How often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PAST MEDICAL HISTORY: *(CIRCLE THE CONDITIONS BELOW THAT APPLY TO YOU)*

Aneurysm: abdominal, thoracic (chest), cerebral (brain), peripheral (legs)	**Genitourinary Disease:** urinary frequency, incontinence, prostate problems
Autoimmune Disorder: lupus, MS, rheumatic fever, Sjogren's syndrome	**Heart Valve Disease:** aortic, mitral, tricuspid
Blood Thinners: Coumadin, Plavix, Aspirin, Xarelto, Pradaxa, Fish Oil	**Hematologic Disease:** anemia, clotting disorder, bleeding disorder
Cancer: what type? _____	**Hyperlidemia** (high cholesterol)
Cardiac Arrhythmias: A-fib, PVC	**Hypertension** (high blood pressure)
Carotid Stenosis	**Kidney Disease**: renal cysts, renal transplant
Congenital Heart Disease: ASD, VSD, AVSD, Marfan's, bicuspid valve	**Liver Disease:** jaundice, hepatitis, cirrhosis
Coronary Artery Disease: heart attack (MI), chest pain	**Musculoskeletal:** arthritis, osteoporosis, back pain
Dermatology: shingles, psoriasis	**Neurologic Disorder:** schizophrenia, bipolar disorder, epilepsy
Diabetes: Type 1 Insulin-Dependent, Type 2 Non-Insulin Dependent	**Pacemaker**
ENT: Ears, Nose, Throat problems	**Peripheral Vascular Disease:** DVT, claudication
End Stage Renal Disease (kidney failure)	**Pulmonary/Respiratory Disease:** asthma, COPD, TB
Endocrine problems: thyroid- high / low, parathyroid- high / low, adrenal gland, pituitary	**Sleep Disorder:** insomnia, sleep apnea, narcoleps
Eye Problems: glasses, cataracts, glaucoma, etc	**Other #1: _____**
Gastrointestinal Disease: ulcers, Crohn's, diverticulitis, gallstones, IBS, reflux/heartburn	**Other #2: _____**

SURGICAL HISTORY: **(***Please list all prior surgeries and dates*)

DATE	SURGERY

SOCIAL HISTORY:

Smoking Status:
❑Never smoked ❑Former smoker ❑Current smoker *daily* ❑Current smoker *occasionally*

Number of years you have used tobacco (**even if you quit**): _____

How much do you (or did you) smoke?❑1 pack per day ❑2 packs per day ❑1 pack per week ❑Other: _____

Alcohol Intake: ❑None ❑Occasional ❑Moderate ❑Heavy

Illicit Drugs: ❑None ❑Yes: (what and how often?) _____

Exercise Level: ❑None ❑Occasional ❑Moderate ❑Heavy

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Domestic Partner

FAMILY MEDICAL HISTORY: *OR* ❑ **None/Unknown**

	Mother ✓	**Father** ✓	**Sister** ✓	**Brother** ✓
Aneurysm				
Heart Attack (MI)				
Bleeding				
Blood Clots (DVT)				
Cancer (List type of Cancer)				
Congenital Heart Disease				
Diabetes				
Heart Failure				
Hypertension				
Hyperlipidemia				
Kidney Failure				
Obesity				
Rheumatic Fever				
Stroke				

PROVIDERS:

- Pharmacy / Location: _____

- Primary Care Doctor or Clinic / Phone #: _____

- Referring Doctor / Phone #: _____

- Other Doctors (*pulmonologist, oncologist, cardiologist, etc*.) / Phone #: _____

_____

Dialysis Unit / Days you dialyze *(if applicable):* _____

Cardiothoracic and Vascular Surgeons - Review Of Systems (ROS)

(please check all the following conditions listed below that you are currently experiencing. If applicable, provide additional notes about the condition)

Patient Name_____ **Patient D.O.B.**_____ **Date**_____ **Athena #** _____
(for staff only)

Constitutional	❑**NONE or:** ❑fever ❑night sweats ❑significant weight gain ❑significant weight loss ❑exercise intolerance ❑fatigue Comments_____
Eyes	❑**NONE or:** ❑dry eyes ❑eye irritation ❑vision changes ❑difficulty reading: needs glasses/contacts Comments_____
Ears	❑**NONE or:** ❑difficulty hearing ❑ear pain Comments_____
Nose	❑**NONE or:** ❑frequent nosebleeds ❑nose/sinus problems Comments_____
Mouth/Throat	❑**NONE or:** ❑sore throat ❑bleeding gums ❑snoring ❑dry mouth ❑mouth ulcers ❑oral abnormalities ❑teeth problems Comments_____
Cardiovascular	❑**NONE or:** ❑chest pain ❑chest pain on exertion ❑shortness of breath when walking ❑shortness of breath when lying down ❑palpitations ❑known heart murmur ❑lightheadedness Comments_____
Respiratory	❑**NONE or:** ❑cough ❑wheezing ❑shortness of breath ❑coughing up blood ❑sleep disturbances (sleep apnea) Comments_____
Gastrointestinal	❑**NONE or:** ❑abdominal pain ❑vomiting ❑abnormal appetite ❑diarrhea ❑vomiting blood ❑black or tarry stools Comments_____
Genitourinary	❑**NONE or:** ❑incontinence (loss of urinary control) ❑difficulty urinating ❑increased urinary frequency ❑hematuria ❑change in urinary output ❑incomplete emptying of bladder Comments_____
Musculoskeletal	❑**NONE or:** ❑muscle aches ❑muscle weakness ❑arthralgias/joint pain ❑back pain ❑swelling in the extremities ❑needs wheelchair ❑needs walker Comments_____
Neurologic	❑**NONE or:** ❑loss of consciousness ❑weakness ❑numbness ❑seizures ❑dizziness ❑frequent/severe headaches ❑migraines ❑restless legs Comments_____
Hematologic/ Lymphatic	❑**NONE or:** ❑swollen glands ❑bruising ❑easy / excessive bleeding tendency Comments_____
Allergic/ Immunologic	❑**NONE or:** ❑runny nose ❑sinus pressure ❑itching ❑hives ❑frequent sneezing Comments_____
Endocrine	❑**NONE or:** ❑excessive thirst or water consumption ❑overall weakness ❑excessive facial or body hair growth ❑temperature intolerance Comments_____
Lung Symptoms *Check the lung symptoms that you are currently having have had.*	❑**NONE or:** ❑Cough ❑Shortness of Breath ❑Bronchitis ❑Enlarged Lymph Nodes ❑Chronic pulmonary heart disease (enlarged heart area from pumping/working harder) ❑Atherosclerosis of aorta (plaque build up in major heart artery) ❑Mucopurulent (yellow/green mucus) Chronic Bronchitis ❑Chronic Airway Obstruction (airways often congested/tight feeling) ❑Hemoptysis (coughing up blood/bloody sputum) ❑Other Chest Pain ❑Tachypnea (very rapid breathing) ❑Swelling mass/lump-Chest ❑Abnormal Chest Sounds (popping, rattling, crackling chest sounds) ❑Abnormal Electrocardiogram (EKG) Comments_____

Cardiothoracic and Vascular Surgeons
1010 W. 40th St., Austin, TX 78756
Tel: (512) 459-8753 Fax: (512) 459-0586

CTVS General Consent Form to the Use and Disclosure of Protected Health Information

I understand that **Cardiothoracic and Vascular Surgeons** creates and maintains medical and related records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is my "protected health information".

I understand and consent to the use and disclosure of my Health Information by Cardiothoracic and Vascular Surgeons for the following purposes:

- My treatment: This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional and participation in SureScripts Pharmacy database.

- Payment for healthcare services provided to me: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.

- My Provider's internal operations: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

- My personal release: I authorize the release of my protected health information to myself at any time.
  I understand and agree that:

- I have the right to review Cardiothoracic and Vascular Surgeons *Notice of Privacy Practices for Protected Health Information*, which provides a much more detailed description of information uses and disclosures, prior to signing this Consent.

- **Cardiothoracic and Vascular Surgeons** may change or modify its *Notice of Privacy Practices for Protected Health Information* at any time and I have the right to obtain a revised notice of privacy practices by accessing the Cardiothoracic and Vascular Surgeon's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

- I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my Provider is not required to agree to any restrictions that I may request, but if my Provider agrees, it will be bound by that restriction.

- I have the right to revoke this Consent by notifying my Provider *in writing* that I revoke this Consent unless my Provider has used or disclosed my Health Information in reliance on this Consent.

- My Provider has the right to disclose relevant Health Information to my family member, other relative, close personal friend, or anyone identified by me.

Cardiothoracic and Vascular Surgeons
1010 W. 40th St., Austin, TX 78756
Tel: (512) 459-8753 Fax: (512) 459-0586

CTVS General Consent Form to the Use and Disclosure of Protected Health Information

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date

_____
Guardian or responsible party signature

I hereby authorize the release of my protected health information to the following individuals:

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

Cardiothoracic and Vascular Surgeons
1010 W. 40th St., Austin, TX 78756
Tel: (512) 459-8753 Fax: (512) 459-0586

FINANCIAL RESPONSIBILITY

I understand that on ALL services billed to my insurance company there may be an additional balance due. This is determined by my insurance company's benefit plan. This includes co-pays and deductibles.

I understand that if my insurance denies the claim(s) for medical necessity, out of network, not a covered benefit, plan terminated, is considered experimental or investigational by my plan, etc. that I will be financially responsible for the payment of the services according to the protocol of this office.

I understand if I am admitted to the hospital there may be other charges for medical services that may be considered out of network with my insurance company for which I may be responsible. CTVS cannot control or guarantee that only in-network providers for your insurance plan will be utilized by the hospital in which you receive treatment.

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date

_____ _____
Guardian or Responsible Party Signature **Relationship to Patient**