

PRE-REGISTRATION FORM

Center for Women's Cardiac Health & Research
 2865 Atlantic Ave, Suite 210
 Long Beach, CA 90806, 562-933.3460; Fax 562 933.3462

How did you find out about the Center: _____ Referral Source: Self Friend MD

Date:	Appointment for:	Preferred Language	
Time:	<input type="checkbox"/> Women's Heart Screening <input type="checkbox"/> Follow-up CV Risk Appointment <input type="checkbox"/> Vascular Screening for Peripheral Arterial Disease (PAD)	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	
Name:		DOB:	Soc. Security No:
Home Address:		City:	State: Zip Code:
Home Phone:		Cell Phone:	Email:
Employed? Yes/No If Yes, Where			Address:
City:		State: Zip Code:	Work Phone:
<input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed for other reasons <input type="checkbox"/> Occupation: _____ <input type="checkbox"/> Retired			
Marital Status: <input type="checkbox"/> Legally married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Living SO			
Religious Preferences: _____			
Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other			
Highest Level of Education: <input type="checkbox"/> Attended high school <input type="checkbox"/> Completed high school <input type="checkbox"/> Attended college, trade school <input type="checkbox"/> Community College Degree <input type="checkbox"/> Baccalaureate Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Doctorate			
Next of Kin/Significant Other:		Relationship to Patient:	
Address:	City:	State:	Zip Code: Phone:
Primary Care Physician Name:		Phone Number:	
Address:	City:	State:	Zip Code:
Does this physician monitor your cholesterol level? <input type="checkbox"/> Yes <input type="checkbox"/> No		Results of Last Total Cholesterol:	
Cardiologist Name:		Phone Number:	
Address:	City:	State:	Zip Code:
Primary Insurance: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None	Policy/ID Number:		Insured's Name:
Secondary Insurance:	Policy/ID Number:		Insured's Name:

Cardiovascular Risk Reduction Program Patient History

Name: (Last, First)	DOB <hr style="border: none; border-top: 1px solid black;"/>	CWCHR Chart File Number: <hr style="border: none; border-top: 1px solid black;"/>
	Sex M F	Medical Record No: (Staff Use) <hr style="border: none; border-top: 1px solid black;"/>

Past Medical History
 Have you ever been **diagnosed** with any of the following conditions or had any of the procedures listed below?

SYSTEM	Please Circle Response	Nurse / Physician Comments
CARDIOVASCULAR		
Atrial Fibrillation	Yes No Unknown	
Blood Clotting Disorder	Yes No Unknown	
Carotid Artery Disorder	Yes No Unknown	
Congestive Heart Failure	Yes No Unknown	
Elevated Cholesterol	Yes No Unknown	
Heart Attack/ Angina	Yes No Unknown	
Heart Murmur	Yes No Unknown	
Heart Surgery / Angioplasty	Yes No Unknown	
High Blood Pressure	Yes No Unknown	
Prosthetic / Artificial Heart Valve	Yes No Unknown	
Blockage of Arm or Leg Blood Vessels	Yes No Unknown	
GASTROINTESTINAL / GENITOURINARY / RESPIRATORY		
Liver Disease/Hepatitis	Yes No Unknown	
Stomach Ulcers	Yes No Unknown	
Inflammatory Bowel Disease	Yes No Unknown	
Kidney / Bladder Disease	Yes No Unknown	
Lung Disease (Asthma; Emphysema; Chronic Bronchitis)	Yes No Unknown	
Tuberculosis	Yes No Unknown	
Other	Yes No Unknown	

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Alcohol Dependency	Yes	No	Unknown	
Cancer	Yes	No	Unknown	
Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	Yes	No	Unknown	
Drug Abuse	Yes	No	Unknown	
Immune System Disorder	Yes	No	Unknown	
Thyroid Disease	Yes	No	Unknown	
Toxic Exposure	Yes	No	Unknown	
Sexually Transmitted Disease	Yes	No	Unknown	
Depression / Other Mental Health Problems	Yes	No	Unknown	
Stroke / Neurological Disorder	Yes	No	Unknown	
Arthritis	Yes	No	Unknown	

OTHER SYMPTOMS

Other Medical Problems: (Please list all medical conditions not listed above)

HEATH HABITS

Smoking: _____ Packs: Per Day (PPD), for _____ years. If stopped, when _____

Alcohol: _____ Drinks Per Day: _____

Exercise: None Occasional Regular Any days really vigorous

Have you had any of the following vaccines? Flu, Date _____ Pneumonia, Date _____

PREVIOUS HOSPITALIZATIONS

Date	Hospital	Problem/Operation

Other Medical Problems: (Please list all medical conditions not listed above)

Cardiovascular Risk Reduction Program

Patient History

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Name: _____ **Date:** _____

Office Exam:

Baseline Physical Exam: Blood Pressure _____ Heart Rate _____ Rhythm _____
 Weight _____ Height _____ % Body Fat _____ BMI _____

Please check any of the following you have experienced in the last year:

1. General:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Change in energy level |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Fevers | |

2. Endocrine:

- | | |
|--|--|
| <input type="checkbox"/> Feeling of excessive warmth or coldness | <input type="checkbox"/> Feeling of excessive thirst or excessive hunger |
| <input type="checkbox"/> Change in the amount you urinate | |

3. Blood and lymphatic:

- | | |
|--|---|
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Enlarged lymph nodes |
| <input type="checkbox"/> Prolonged or excessive bleeding | <input type="checkbox"/> Enlarged tonsils |
| <input type="checkbox"/> Blood clots in your legs | |

4. Mental health:

- | | |
|---|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Undue sadness or depression | <input type="checkbox"/> Trouble with your sleep |
| <input type="checkbox"/> Thoughts of ending your life | <input type="checkbox"/> Thoughts of harming yourself or others |

5. Skin:

- | | |
|---|--|
| <input type="checkbox"/> Change in the texture or amount of your hair | <input type="checkbox"/> Changes in your skin or nails |
| <input type="checkbox"/> New rashes | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Sores or changes in any moles | |

Cardiovascular Risk Reduction Program
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Please check any of the following you have experienced in the last year:

6. Eyes:

- | | |
|--|--|
| <input type="checkbox"/> Changes in vision | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Red or painful eyes |

7. Ears:

- | | |
|---|---|
| <input type="checkbox"/> Changes in hearing | <input type="checkbox"/> Pain or drainage from ears |
| <input type="checkbox"/> Ringing in your ears | <input type="checkbox"/> Dizziness with or without changes in head position |

8. Nose and sinuses:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Increase in frequency of colds or nasal drainage | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Allergies |

9. Mouth, throat and teeth:

- | | |
|--|--|
| <input type="checkbox"/> Tongue or mouth sores | <input type="checkbox"/> Recent dental work |
| <input type="checkbox"/> Hoarseness or voice changes | <input type="checkbox"/> Problems swallowing |
| <input type="checkbox"/> Bleeding of gums | |

10. Neck:

- | | |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Pain | |

11. Breasts/Chest:

- | | |
|---|---|
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Milk production (if breastfeeding) |

12. Respiratory:

- | | |
|--|--|
| <input type="checkbox"/> New cough | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Wheezing or shortness of breath | <input type="checkbox"/> Pain with breathing |

13. Cardiac:

- | | |
|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pressure or unusual feeling in chest |
| <input type="checkbox"/> Palpitations/Unusual heart beat | <input type="checkbox"/> Shortness of breath with activity |
| <input type="checkbox"/> Swelling in your ankles | <input type="checkbox"/> Shortness of breath lying down |
| <input type="checkbox"/> Fainting or passing out spells | |

14. Blood vessels:

- | | |
|--|---|
| <input type="checkbox"/> Pain in your legs with walking | <input type="checkbox"/> Sensitivity or change in color of your fingers or toes |
| <input type="checkbox"/> Varicose veins with cold temperatures | |

15. Gastrointestinal:

- | | |
|---|--|
| <input type="checkbox"/> Changes in your appetite | <input type="checkbox"/> Indigestion or constipation |
|---|--|

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Please check any of the following you have experienced in the last year:

- | | |
|--|--|
| <input type="checkbox"/> Trouble swallowing
<input type="checkbox"/> Nausea <input type="checkbox"/>

<input type="checkbox"/> Vomiting appearance
<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> | <input type="checkbox"/> Diarrhea
<input type="checkbox"/> Recent change in frequency, consistency, color or of stool
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Black, tarry appearance of stool |
|--|--|

16. Urinary:

- | | |
|--|--|
| <input type="checkbox"/> Change in frequency of urination <input type="checkbox"/>
<input type="checkbox"/> Burning on urination <input type="checkbox"/>
<input type="checkbox"/> Hesitancy | <input type="checkbox"/> Change in volume of urine or stream
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Urgency or incontinence (loss of control of urine) |
|--|--|

17. Male genito/reproductive:

- | | |
|--|--|
| <input type="checkbox"/> Sores on penis
<input type="checkbox"/> Difficulties with erection | <input type="checkbox"/> Pain or masses in testicles |
|--|--|

18. Female genito / reproductive:

- | | |
|--|---|
| <input type="checkbox"/> Changes in duration, amount or frequency of menses
<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Painful sexual intercourse | <input type="checkbox"/> Lack of sexual desire
<input type="checkbox"/> Vaginal dryness
<input type="checkbox"/> Vulvar itching |
|--|---|

19. Musculoskeletal:

- | | |
|--|--|
| <input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Tenderness
<input type="checkbox"/> Pain or swelling in any joints | <input type="checkbox"/> Muscle pain
<input type="checkbox"/> Stiffness |
|--|--|

20. Neurologic:

- | | |
|---|--|
| <input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness or tingling of hands or feet <input type="checkbox"/>
<input type="checkbox"/> Difficulty speaking
<input type="checkbox"/> Abnormal movements
<input type="checkbox"/> Recent falls | <input type="checkbox"/> Blackouts or near blackouts
<input type="checkbox"/> Chronic pain
<input type="checkbox"/> Memory loss or difficulty concentrating
<input type="checkbox"/> Weakness
<input type="checkbox"/> Problems with balance |
|---|--|

Healthcare Provider Signature

Date