



Mary Washington Cardiology

Patient Registration

Date: _____

Patient Information

Legal Name: _____ Date of Birth: ____ / ____ / ____

Preferred Name (If different from legal name): _____

Preferred Pronoun (Please circle): She / Her He / Him They / Them

Race: American Indian or Alaska Native Asian Ethnicity: Hispanic or Latino
 Black or African American White Not Hispanic or Latino
 Decline to provide Other Decline to provide

Preferred language (if not specified, English will be chosen as your preferred language): _____

Contact preference: Mobile /texting Home Phone Work Phone Email (provide email address)

Home Address: _____

Mailing Address (if different) _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Address: _____

Guarantor / Responsible Party

Name: _____ Date of Birth: ____ / ____ / ____

Relationship to patient: Self Parent Legal Guardian Family Member Other: _____

Status: Single Married Divorced Widowed Other: _____

Home Address: _____

Mailing Address (if different) _____

Emergency Contact(s)

Name: _____ Phone: _____

Relationship to patient: Parent Legal Guardian Family Member Other: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Phone: _____

Relationship to patient: Parent Legal Guardian Family Member Other: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Insurance PRIMARY INSURANCE

Name: _____ Address: _____

Subscriber/Member ID #: _____ Employer: _____

Subscriber Name: _____ Date of Birth: ____ / ____ / ____

Group #: _____ Relationship to patient: _____

Insurance SECONDARY INSURANCE

Name: _____ Address: _____
Subscriber/Member ID #: _____ Employer: _____
Subscriber Name: _____ Date of Birth: _____ / _____ / _____
Group #: _____ Relationship to patient: _____

Please Answer All Questions

What is your reason for today's visit? _____

1. When did the problem/discomfort start? _____
2. Where is the problem/discomfort located? _____
3. What makes it worse? _____
4. If there are any other symptoms associated with this problem please describe _____

General Review Of Systems Are you currently having any of the following symptoms? (Please circle yes or no)

Constitutional:

Y N Recent weight change
Y N Fever
Y N Chills
Y N Fatigue

Eyes:

Y N Blurred/impaired vision

ENT:

Y N Hearing loss
Y N Ringing in ears
Y N Nose bleeds
Y N Bleeding gums
Y N Sore throat or voice change
Y N Swollen glands in neck

Cardiovascular:

Y N Chest pains/discomfort
Y N Sudden heart beat changes
Y N Palpitations/racing heart beat
Y N Swelling of feet, ankles or hands

Respiratory:

Y N Frequent coughing
Y N Sputum productive cough
Y N Spitting up blood
Y N Shortness of breath
Y N Asthma or wheezing

Gastrointestinal:

Y N Loss of appetite
Y N Change in bowel movements
Y N Nausea
Y N Vomiting
Y N Frequent diarrhea
Y N Painful bowel movements/constipation
Y N Blood in stool

Y N Stomach pain

Y N Heartburn

Y N Reflux

Genitourinary:

Y N Frequent urination
Y N Burning or painful urination
Y N Blood in urine
Y N Incontinence or dribbling
Y N Kidney stones
Y N Sexual difficulty
Y N Erection Problems

Musculoskeletal:

Y N Joint pain
Y N Joint stiffness or swelling
Y N Weakness of muscles/joints
Y N Muscle pain or cramps
Y N Back pain
Y N Cold extremities
Y N Leg pain with walking
Y N Leg swelling
Y N Limb weakness

Skin:

Y N Rash
Y N Itching skin
Y N Change in skin color
Y N Varicose veins
Y N Easily bruise
Y N Non-healing sores

Psychiatric:

Y N Memory loss or confusion
Y N Nervousness
Y N Depression
Y N Sleep problems
Y N Suicidal thoughts

Neurological:

Y N Syncope/Passing out
Y N Near Syncope
Y N Headaches
Y N Lightheaded
Y N Dizziness
Y N Convulsions or seizures
Y N Numbness or tingling
Y N Tremors
Y N Paralysis
Y N Stroke
Y N Head injury
Y N Slurred speech

Endocrine:

Y N Thyroid disease
Y N Diabetes
Y N Excessive thirst
Y N Excessive urination
Y N Heat or cold intolerance
Y N Dry skin

Hematologic/Lymphatic:

Y N Slow to heal after cuts
Y N Bleeding tendencies
Y N Anemia

List all allergies that you have:

Please list all PRESCRIPTION medications that you take

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all OVER THE COUNTER medications that you take

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History: (Check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> COPD | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HIV Disease/exposure |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Blood Clot in Legs | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hepatitis (A, B or C) |
| <input type="checkbox"/> Heart Block | <input type="checkbox"/> Blood Clot in Lungs | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Hereditary Heart Defect | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Heart Murmur Previous | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | |

Please provide information about previous surgeries and hospitalizations (include date or year)

Surgeries / Procedures

Coronary Bypass _____ Date _____

Cardiac Cath _____ Date _____

Angioplasty / Stent _____ Date _____

Pacemaker _____ Date _____

Defibrillator _____ Date _____

Other _____ Date _____

_____ Date _____

Hospitalizations

Admitted for _____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Please provide information about previous testing (include date and location)

Stress Test _____ Date _____ Location _____	Holter Monitor _____ Date _____ Location _____
Nuclear Test _____ Date _____ Location _____	Event Monitor _____ Date _____ Location _____
Echo _____ Date _____ Location _____	Heart Scan _____ Date _____ Location _____
24 hr BP Monitor _____ Date _____ Location _____	PAD Testing _____ Date _____ Location _____

Does anyone in your family have or had Heart Disease, Heart Attack, Stroke, High Cholesterol, High Blood Pressure, Diabetes, Sudden Death or Cancer?

- Father Age_____ Disease(s) _____ Cause of death, if deceased _____
 - Mother Age_____ Disease(s) _____ Cause of death, if deceased _____
 - Siblings Age_____ Disease(s) _____ Cause of death, if deceased _____
 - Siblings Age_____ Disease(s) _____ Cause of death, if deceased _____
 - Siblings Age_____ Disease(s) _____ Cause of death, if deceased _____
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Social History:

Use of Tobacco: Yes No Explanation: _____ Previous Yes No Year Quit _____

Use of Alcohol: Yes No | Caffeine: Yes No | Special Diet: Yes No _____

Patient Signature: _____ Date: _____
