Orlando Health Cardiovascular and Thoracic Surgery

EVALUATION AND MANAGEMENT HISTORY INFORMATION FORM

Date: _____ Patient Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

_____ _____

General Practitioner/Primary Doctor | Referring Physician/Specialist

REVIEW OF SYSTEMS - PLEASE CHECK EACH ITEM "YES" OR "NO"
AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL	**Yes**	**No**
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Change in Appetite	☐	☐

EYES	**Yes**	**No**
Glasses / Contacts	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

EAR, NOSE, THROAT	**Yes**	**No**
Ringing in ears	☐	☐
Vertigo	☐	☐
Frequent Sore Throat	☐	☐
Hoarseness	☐	☐
Frequent Nosebleeds	☐	☐

GENITOURINARY	**Yes**	**No**
Pain Urinating	☐	☐
Burning	☐	☐
Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
History of Sexually Transmitted Disease	☐	☐

RESPIRATORY	**Yes**	**No**
Shortness of Breath	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Persistent Cough	☐	☐
Frequent Infections	☐	☐

GASTROINTESTINAL	**Yes**	**No**
Abdominal Pain	☐	☐
Nausea / Vomiting	☐	☐
Heartburn	☐	☐
Rectal Bleeding	☐	☐
Blood / Black Stools	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

CARDIOVASCULAR	**Yes**	**No**
Chest Pain	☐	☐
Jaw Pain	☐	☐
Arm Pain	☐	☐
Calf Pain	☐	☐
Palpitations	☐	☐
Swelling of Extremities	☐	☐

HEMATOLOGIC	**Yes**	**No**
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
Prolonged Bleeding	☐	☐

MUSCOLOSKELETAL	**Yes**	**No**
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐

NEUROLOGICAL	**Yes**	**No**
Seizures	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Memory Loss	☐	☐
Loss of Consciousness	☐	☐

SKIN	**Yes**	**No**
Rash/Sores	☐	☐
Lesions	☐	☐
Itching	☐	☐
Burning	☐	☐

	Yes	**No**	(If "yes," please list details):
1. Have you ever had a vein stripping?	☐	☐	_____
2. Have you ever had chest trauma?	☐	☐	_____
3. Have you ever had a problem with anesthesia?	☐	☐	_____
4. Have you ever had a blood transfusion?	☐	☐	_____
5. Do you object to receiving blood products?	☐	☐	_____

Orlando Health Cardiovascular and Thoracic Surgery

EVALUATION AND MANAGEMENT HISTORY INFORMATION FORM

PAST PATIENT HISTORY - Please list below ALL Your Past Operations, Hospitalizations, Illnesses/Injuries PLEASE BE SPECIFIC AS TO REASON AND DATES	
Please list all past operations/hospitalizations with reason & date	Please list all personal illnesses/injuries and dates

PAST PATIENT HISTORY - PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR PAST PERSONAL HISTORY					
CONDITION	Yes	No	CONDITION	Yes	No
INFECTIOUS DISEASES			**ENDOCRINE**		
Hepatitis	☐	☐	Diabetes	☐	☐
HIV/AIDS	☐	☐	Thyroid Problems	☐	☐
Polio	☐	☐	**GASTROINTESTINAL**		
Rheumatic Fever	☐	☐	Stomach Ulcer	☐	☐
Tuberculosis	☐	☐	Gallstones	☐	☐
CARDIOVASCULAR			Liver Disease	☐	☐
High Cholesterol	☐	☐	**RENAL/GENITOURINARY**		
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Birth Defect of Heart	☐	☐	Kidney Stones	☐	☐
Heart Murmur	☐	☐	Prostate Problems	☐	☐
Pericarditis	☐	☐	Urinary Tract Infections	☐	☐
Heart Attack	☐	☐	**MUSCULOSKELETAL**		
Previous Stent or Angioplasty	☐	☐	Gout	☐	☐
Irregular Heart Beats	☐	☐	Arthritis	☐	☐
Peripheral Vascular Disease	☐	☐	Back Pain	☐	☐
PULMONARY			Herniated Disc	☐	☐
Lung Disease	☐	☐	**HEMATOLOGIC/ONCOLOGY**		
Prior Pneumonia	☐	☐	Anemia	☐	☐
Exposure to Inhaling Hazardous Agent	☐	☐	Cancer - List Type	☐	☐
NEUROLOGIC			Bleeding Problems	☐	☐
Stroke/TIA	☐	☐	Blood Clots	☐	☐
Migraines	☐	☐			
Seizure Disorder	☐	☐			

PAST PATIENT HISTORY - PLEASE COMPLETE THE FOLLOWING TABLE		
	Health Problems	If deceased, age and cause of death
Mother		
Father		
Siblings		
Grandparents		

Orlando Health Cardiovascular and Thoracic Surgery

EVALUATION AND MANAGEMENT HISTORY INFORMATION FORM

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS OR OVER THE COUNTER MEDICATIONS AND DOSAGES					
Med Name	Dose	Frequency (# times per day)	Med Name	Dose	Frequency (# times per day)

Are there any medications which you stopped taking in the past month? ☐Yes ☐No

If you answered "yes", which medications have you stopped? _____

Are you currently taking Aspirin? ☐Yes ☐No How often? _____

Are you allergic to any medication? ☐Yes ☐No List what medication(s) _____

Describe the type of allergic reaction you had to this medication _____

SOCIAL HISTORY – PATIENT PLEASE ANSWER THE FOLLOWING QUESTIONS

Yes No

☐ ☐ Have you ever smoked?
If yes: # packs/day_____ # years smoked_____

☐ ☐ Are you still smoking?
If you have stopped smoking, when did you quit? _____

☐ ☐ Do you drink alcohol? If yes, please list type and quantity: _____

☐ ☐ Do you use recreational drugs? What type _____

☐ ☐ Do you exercise? Type Miles Times/day/week _____

Place of Birth: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

If surgery is planned, will you have help at home to assist in your recovery? ☐Yes ☐No

If no, what type of assistance do you feel that you may need? _____

_____

Current Occupation: _____ If retired, from what? _____

Have you recently traveled outside of the United States? ☐Yes ☐No

If you answered "yes", where did you travel to and when? _____

Orlando Health Cardiovascular and Thoracic Surgery

Mark E. Sand, M.D.
Jeffrey N. Bott, M.D.

Appointment _____
Provider _____
Patient # _____

Our Surgeons use Physician Assistants, PA-C to assist in surgery. Please call your insurance carrier to verify whether your policy covers a PA as a surgical assistant. If they cover surgical assistants, they may only allow a surgeon who is an MD to assist. If your insurance does not cover this charge, you will be responsible for payment of the assistant surgeon charges as with any other non-covered charge.

Last Name: _____ First Name: _____ Middle: _____

Address: _____ Gender: _____

_____ Marital Status: _____

_____ Social Security #: _____

Home Phone: _____ Date of Birth: _____

Work Phone: _____ Your Employer: _____

Cell Phone: _____

Alternative Contact Name: _____

Relation: _____

Home: _____

Work: _____

Cell: _____

Please provide a number other than one listed in the patient section above. Only one number is needed.

Primary Insurance	*Secondary Insurance*
Policyholders Name:	*Group #:*
Policyholders Date of Birth:	*Policy #:*
Phone:	

Referring Physician:	*Primary Care Physician:*	Family Physician:

MEDICAL RECORDS RELEASE AND ASSIGNMENT OF BENEFITS

I authorize Orlando Health Cardiovascular and Thoracic Surgery to act in my behalf when inquiring to Medicare, Social Security Administration and/or my health insurance carrier, regardless to whom benefits are assigned, for the purpose of obtaining information regarding payment of this claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I authorize the release of medical information to/from referring physicians and suppliers and to my insurance carrier for the purpose of processing payment of insurance benefits. I am responsible for all financial obligations and should it become necessary to pursue collection of this debt, I (we) agree to pay all costs of collection including a reasonable attorney's fee. I understand and therefore, I acknowledge and accept liability of payment for these services.

Date: _____ Signature: _____