Heart Rhythm Associates, PA

Patient Health Questionnaire

Patient Name_____ Date of visit_____

Date of Birth_____ Age_____ Sex M F Height_____Weight_____

What health concern or condition are we seeing you for today?_____

_____

Who is your general cardiologist?_____Number_____

Who is your primary care physician?_____Number_____

Current Medication

Current medications you are taking. Please include all prescribed and over the counter medication.

Medication	Strength	How often

Drug and Food Allergies

Please list any medications you are allergic to and reactions you may have due to these medications.

	Yes	No	Describe Reaction
Any Medications			
Iodine or shellfish			
X-ray dye or IV contrast			
Other			

Do you drink alcohol on a regular basis? Yes No
If no, did you drink heavily in the past? Yes No
If yes, how much do you typically drink in one week? _____
Do you follow any specific diet? Yes No If yes, what kind_____
Do you now or have you ever smoked tobacco products? Yes No
If cigarettes, number of packs per day_____ Number of years_____
If cigars, number per day_____ Number of years_____
If pipes, number per day_____ Number of years_____
Have you quit? Yes No If yes, when was your last cigarette, cigar or pipe?_____
Do you drink coffee or tea? Yes No If yes, how many cups per day_____
Do you drink caffeinated energy drinks? Yes No If yes, how many per day_____
Do you exercise? Yes No If yes, what kind of exercise and how often_____
Are you able to perform activities of daily living? Yes No
Do you use recreational drugs? Yes No
Have you ever been treated for substance abuse? Yes No

Constitutional

fatigue	O Yes	O No
fever	O Yes	O No
weakness	O Yes	O No
weight gain	O Yes	O No
weight loss	O Yes	O No
loss of appetite	O Yes	O No
headache	O Yes	O No
appetite reduced	O Yes	O No

ENT

cough	O Yes	O No
cold symptoms	O Yes	O No
sinus pain	O Yes	O No
loss of hearing	O Yes	O No
ringing in ears	O Yes	O No
change in voice	O Yes	O No

Cardiovascular System

heart murmur	O Yes	O No
pauses in heart beat	O Yes	O No
palpitations	O Yes	O No
chest pain at rest	O Yes	O No
chest pain with exertion	O Yes	O No
leg edema	O Yes	O No
leg pains	O Yes	O No
shortness of breath at rest	O Yes	O No
shortness of breath on exertion	O Yes	O No
dizziness	O Yes	O No
sweats	O Yes	O No

Nervous System

"Mini-Stroke" or TIA	O Yes	O No
Fainting/ passing out	O Yes	O No
dizziness or lightheaded	O Yes	O No

Dermatology

rash	O Yes	O No
non-healing sores or ulcers	O Yes	O No
acne	O Yes	O No

Pulmonary System

sore throat	O Yes	O No
recent bronchitis	O Yes	O No
shortness of breath at rest	O Yes	O No
Coughing up blood	O Yes	O No
Chronic Cough	O Yes	O No
chest congestion	O Yes	O No
expiratory wheezing	O Yes	O No
COPD exacerbation	O Yes	O No

Gastrointestinal

nausea	O Yes	O No
heart burn	O Yes	O No
frequent diarrhea	O Yes	O No
constipation	O Yes	O No
nocturnal heart burn	O Yes	O No
vomiting	O Yes	O No
difficulty swallowing	O Yes	O No
abdominal pain	O Yes	O No
blood in stool	O Yes	O No

Circulation

pain in legs with exercise	O Yes	O No
Ankle or leg swelling	O Yes	O No
Discoloration of feet or legs	O Yes	O No

Renal/Urinary

dribbling or incontinence	O Yes	O No
pain or burning with urination	O Yes	O No
kidney stones or infection	O Yes	O No

Male reproductive

Erectile dysfunction	O Yes	O No
Have you had a vasectomy?	O Yes	O No

Musculoskeletal

leg cramps	O Yes	O No
joint pain	O Yes	O No
back pain	O Yes	O No
joint swelling	O Yes	O No

Family History

Does your Mother have history of: O Hypertension O Diabetes O Coronary Artery Disease
O High Cholesterol O Heart Problems O Lung Problems O Palpitations O Cancer

Does your Father have history of: O Hypertension O Diabetes O Coronary Artery Disease
O High Cholesterol O Heart Problems O Lung Problems O Palpitations O Cancer

Does your Siblings have history of: O Hypertension O Diabetes O Coronary Artery Disease
O High Cholesterol O Heart Problems O Lung Problems O Palpitations O Cancer

Does your Father's parents have history of: O Hypertension O Diabetes
O Coronary Artery Disease O High Cholesterol O Heart Problems O Lung Problems
O Palpitations O Cancer

Does you Mother's parents have history of: O Hypertension O Diabetes
O Coronary Artery Disease O High Cholesterol O Heart Problems O Lung Problems
O Palpitations O Cancer

Past Medical History

Asthma	O Yes	Hypercholestrolemia	O Yes
Diabetes	O Yes	Hypothyroidism	O Yes
Atrial fibrillation	O Yes	CHF	O Yes
COPD	O Yes	Arthritis	O Yes
GERD	O Yes	Gout	O Yes
Anemia	O Yes	Mitral prolapse	O Yes
Palpitations	O Yes	DVT	O Yes
Pulmonary embolism	O Yes	Tuberculosis	O Yes
Cardiomyopathy	O Yes	Hypertension	O Yes
Rheumatic heart disease	O Yes	Respiratory disease	O Yes
Bowel disorders	O Yes	Varicose veins	O Yes
Thyroid disease	O Yes	Cancer	O Yes
Kidney disease	O Yes	Mitral valve regurgitation	O Yes
Mitral valve stenosis	O Yes	Aortic stenosis	O Yes
Cirrhosis	O Yes	stroke	O Yes

IF there is any history that you have that is not listed please note_____

Surgical History

Cholecystectomy	O Yes	Appendectomy	O Yes
Tonsillectomy	O Yes	Cesarean section	O Yes
Hysterectomy, abdominal	O Yes	Cardiac catheterization	O Yes
Thyroidectomy	O Yes	Heart stent	O Yes
Hernia repair	O Yes	Gallbladder	O Yes

If there is any surgery that you have had that is not listed please note_____

Patient Demographics / Insurance Information

Patient Name:_____ _Date of Birth:_____

Address:_____City:_____St:____Zip____

Phone Number: (H)_____ (C)_____(W)_____

Social Security #_____ Email Address:_____

Please circle Race: White Hispanic/ Latino Black/African American
American Indian or Alaskan Native Native Hawaiian or other pacific islander other race

Please Circle Gender: Male or Female

Please circle Marital Status: Married Single Divorced Widowed Separated

Employer Name:_____Job Title:_____ Work #_____

Emergency Contact Information

Emergency Contact:_____ Relationship:_____

Phone Number_____

Insurance Information

Primary Insurance:_____

Insurance Claim Address:_____

Customer Service Number:_____

Policy Number:_____Group Number:_____

Secondary Insurance:_____

Insurance Claim Address:_____

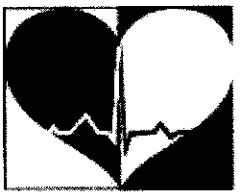
Customer Service Number:_____

Policy Number:_____Group Number:_____

Pharmacy Name:_____ **Phone Number:**_____

I hereby confirm that the above information is correct to the best of my knowledge.

Signature:_____ Date: _____



Heart
Rhythm
Associates, P.A.

Due to the new law enacted by congress, we are required to have you sign this form to receive treatment by the Cardiologist.

1. You must consent to a medical examination and any procedures or test deemed necessary by Heart Rhythm Associates, PA while you are in our office
2. You agree that either Heart Rhythm Associates, PA can release medical information to your primary care doctor and or the physician who referred you to our office.
3. You consent to our releasing information about appointments and or test results to anyone you designate

Name:_____ Relationship: _____

This consent to be in effect indefinitely or until you have revoked it. You may revoke this consent at any time. By revoking consent for further treatment does not relieve you from any financial obligations which were incurred during the period this consent was effective.

Assignment of Benefits

I hereby authorize direct payment of surgical/medical benefits to Heart Rhythm Associates, PA for services rendered by him/her or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization for Release of Information

I hereby authorize Heart Rhythm Associates, PA to release my medical information that may be necessary for either medical care of processing applications for financial benefits.

Medicare and Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

HIPPA Individual Acknowledgement of Privacy Practice

By signing this paper, I am indicating that I have been provided a copy of the Notice of Privacy Rights Practice

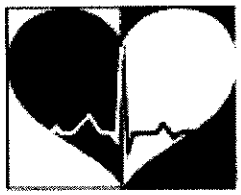
I understand that the notice of privacy practice can change. I can obtain a current notice by contacting the staff.

Consent to Treat

I (or my legal guardian or parent) authorize Heart Rhythm Associates, PA to provide medical care reasonable by today's standards.

Patient Signature: _____

Date:_____



Heart
Rhythm
Associates, P.A.

Release of Medical Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Heart Rhythm Associates, P.A. to obtain my protected health information (medical records) described below that may be necessary for treatment from:

Facility/Hospital _____ Phone #: _____
(Name and Address)

Doctor's Office _____ Phone #: _____
(Name and Address)

Copies of the following records shall be used and disclosed:

_____ Complete Medical Records: or

_____ Other: _____

Reason for disclosure _____

I understand that copies of the records indicated above will be:

_____ Sent to:
Heart Rhythm Associates, PA
920 Medical Plaza Dr. Suite 300
The Woodlands, Texas 77380

_____ Faxed to:
Heart Rhythm Associates, PA
281-296-0780

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to Recipient and, therefore, may be subject to re-disclosure by the Recipient.

Signature of Patient _____ Date _____

Witness _____ Date _____

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange