Heart Care Centers of Illinois

PATIENT INTRODUCTION **Today's Date: _____**

Name _____ Date of Birth: _____
Last First Middle

Address _____ Home Phone # _____

_____ Cell Phone # _____
City State Zip

Social Security #: _____ Sex: _____ Male _____ Female

Who Is Your Primary Care Physician?_____

Are you employed? _____ Yes _____ No _____ Retired If retired, when _____

Employer Name: _____ Work Phone #: _____

_____ _____
Employer Street Address City State Zip

SPOUSE INFORMATION

Name _____ Date of Birth: _____
Last First Middle

Social Security #: _____ Is Spouse employed? _____ Yes _____ No _____ Retired

Spouse's Employer Name: _____ Work Phone #: _____

_____ _____
Spouse's Employer Street Address City State Zip

In Case of Emergency
Please Contact: _____ Relationship: _____ Phone #: _____

INSURANCE INFORMATION – PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST FOR PHOTOCOPYING

Primary Insurance Name: _____ Effective Date: _____

Group Name or Group #: _____ Policy or ID#: _____

Insured Party (Policyholder) Name: _____

Patient's Relationship to Insured Party: _____ Self _____ Spouse _____ Child _____Other

Secondary Insurance Name: _____ Effective Date: _____

Group Name or Group #: _____ Policy or ID #: _____

Insured Party (Policyholder) Name: _____

Patient's Relationship to Insured Party: _____Self _____ Spouse _____Child _____Other

Heart Care Centers of Illinois

Patient Information Update

Please provide us with the following additional information:

LAST NAME: _____ TODAY'S DATE: ____/____/____

FIRST NAME: _____ DOB: ____/____/____

RACE:

□ African-American □ Asian □ Caucasian / White
□ American Indian □ Native Hawaiian / Other Pacific Islander □ Unknown / Other

The Federal Government has requested we ask this information. If you refuse, please check here: □

ETHNICITY:

□ Non-Hispanic / Non-Latino □ Hispanic / Latino □ Unknown

The Federal Government has requested we ask this information. If you refuse, please check here: □

PRIMARY LANGUAGE:

□ English □ Spanish □ Polish □ Other

The Federal Government has requested we ask this information. If you refuse, please check here: □

Preferred Pharmacy *(please provide as much detail as possible)*:

NAME: _____ ADDRESS: _____

CITY: _____ ZIP CODE: _____ PHONE #: _____

Secondary Pharmacy *(please provide as much detail as possible)*:

NAME: _____ ADDRESS: _____

CITY: _____ ZIP CODE: _____ PHONE #: _____

Do we have permission to obtain your Prescription History electronically? □ YES □ NO

_____ _____

Signature Date

Heart Care Centers of Illinois

PATIENT HISTORY

NAME: _____ DATE: _____
(Last) (First) (Middle)

DATE OF BIRTH: _____ AGE: _____ REFERRING DOCTOR: _____ OCCUPATION: _____

MEDICAL HISTORY

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION	DOSE (mg)	FREQUENCY	START DATE

DO YOU HAVE ANY ALLERGIES? YES (☐) NO (☐) IF YES, PLEASE LIST THEM WITH TYPE OF REACTION:

_____

PLEASE INDICATE WHETHER OR NOT YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

INDICATE	*YES*	*NO*	*INDICATE*	*YES*	*NO*
CHEST PAIN / ANGINA	☐	☐	GOUT	☐	☐
CORONARY ARTERY DISEASE	☐	☐	DIZZINESS / FAINTING	☐	☐
HEART MURMUR	☐	☐	EPILEPSY	☐	☐
HEART ATTACK	☐	☐	ANXIETY	☐	☐
BYPASS SURGERY	☐	☐	GLAUCOMA / EYE DISORDERS	☐	☐
ANGIOPLASTY (BALLOON)	☐	☐	THYROID DISEASE OR PROBLEM	☐	☐
ROTABLATOR	☐	☐	SHORTNESS OF BREATH	☐	☐
STENT	☐	☐	ASTHMA	☐	☐
HEART VALVE SURGERY	☐	☐	COPD / EMPHYSEMA	☐	☐
CAROTID BLOCKAGE	☐	☐	PEPTIC ULCER	☐	☐
LEG CIRCULATION PROBLEMS	☐	☐	PANCREATITIS	☐	☐
STROKE / TIA	☐	☐	GALLBLADDER DISEASE	☐	☐
CONGENITAL HEART DISEASE	☐	☐	LIVER DISEASE, JAUNDICE, HEPATITIS	☐	☐
RHEUMATIC HEART DISEASE	☐	☐	INTESTINAL PROBLEM (COLITIS), ETC.	☐	☐
CONGESTIVE HEART FAILURE	☐	☐	KIDNEY DISEASE	☐	☐
HEART PALPITATIONS	☐	☐	URINARY PROBLEMS	☐	☐
LEG PAIN WHILE WALKING	☐	☐	FATIGUE	☐	☐
ANEURYSM	☐	☐	ANEMIA	☐	☐
PACEMAKER OR DEFIBRILLATOR	☐	☐	BLEEDING DISORDER	☐	☐
HIGH CHOLESTEROL	☐	☐	ARTHRITIS	☐	☐
HIGH TRIGLYCERIDES	☐	☐	CANCER	☐	☐
HIGH BLOOD PRESSURE	☐	☐	HIV / AIDS	☐	☐
DIABETES	☐	☐	PSYCHIATRIC PROBLEMS	☐	☐

OTHER: (PLEASE MAKE ANY COMMENTS IN REGARDS TO THE ABOVE: _____

_____

PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU MAY HAVE:

_____

PLEASE LIST ANY HOSPITALIZATIONS WITHIN THE LAST TWO YEARS:

NAME OF HOSPITAL	DATE (S)	REASON FOR HOSPITALIZATION

GYNECOLOGICAL HISTORY (WOMEN ONLY):

HAVE YOU HAD A HYSTERECTOMY? YES (☐) NO (☐)
HAVE YOU GONE THROUGH MENOPAUSE? YES (☐) NO (☐)
DO YOU TAKE HORMONE REPLACEMENT? YES (☐) NO (☐)

SURGICAL HISTORY:

NAME OF OPERATION	DATE	COMPLICATIONS (if any)

PERSONAL HABITS:

DO YOU SMOKE? YES (☐) NO (☐) QUIT: _____ HOW LONG AGO? _____
IF YES OR QUIT, HOW MUCH DO (OR DID) YOU SMOKE PER DAY?_____
HOW LONG HAVE (OR HAD) YOU BEEN SMOKING?_____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES (☐) NO (☐)
IF YES, HOW MANY OUNCES DO YOU AVERAGE PER WEEK?
_____ Oz. Liquor _____Oz. Wine _____ Oz. Beer

DO YOU USE (OR HAVE YOU USED) ILLEGAL DRUGS? YES (☐) NO (☐)
DO YOU USE (OR HAVE YOU USED) INTRAVENOUS DRUGS? YES (☐) NO (☐)
DATE LAST USED: _____

DO YOU EXERCISE REGULARLY? YES (☐) NO (☐) HOW LONG/OFTEN?_____
WHAT DO YOU DO?_____HOW LONG?_____HOW OFTEN?_____
HOW MUCH CAFFEINE DO YOU CONSUME DAILY? (CUPS OF COFFEE, TEA, SODA) _____

FAMILY HISTORY:

HAVE ANY OF YOUR FAMILY MEMBERS HAD ANY OF THE FOLLOWING PROBLEMS:

(PLEASE USE M (MOTHER), F (FATHER), S (SISTER), B (BROTHER), C (CHILDREN))

PROBLEM	FAMILY MEMBER(S) AND AGE OF ONSET FOR EACH
STROKE	
HEART ATTACK	
HEART BYPASS SURGERY / ANGIOPLASTY / STENT	
DIABETES	
HIGH BLOOD PRESSURE	
CHOLESTEROL / TRIGLYCERIDES	
LEG CIRCULATION PROBLEMS	
CAROTID (NECK) BLOCKAGE	

PLEASE ADD ANY PERTINENT FAMILY HISTORY: _____

_____

_____

Patient Communication Consent Form

At Heart Care Center of Illinois, we strive to provide you with excellent care and timely communication. By signing this form, you consent to receive messages from Heart Care Center of Illinois regarding your scheduled and unscheduled appointments through the following methods:

- **Email**
- **SMS (Text Messages)**
- **Phone Calls**

Consent Details:

- By providing your contact information, you agree to receive communications from Heart Care Center of Illinois related to appointment reminders, scheduling updates, and other relevant notifications.
- **SMS Messages**: You may receive text messages that include appointment reminders and updates. Message frequency may vary. Standard message and data rates may apply.
- **Opt-Out Option**: You can reply **STOP** at any time to opt out of receiving further text messages from Heart Care Center of Illinois. For additional support, you may reply **HELP** or contact our office directly at (**Your Practice Phone Number).**
- **Privacy Policy**: For more information about how we protect your information, please review our privacy policy available on our website at **https://www.heartcc.com/.**

Patient Acknowledgment:

I understand that message and data rates may apply, and that I may opt out of receiving text messages at any time by replying **STOP**. I also acknowledge that I have been informed about Heart Care Center of Illinois' privacy policy.

I am opting in to receive Text / Email / Phone Call communications from Heart Care Center of Illinois by the contact information I provide below:

Patient Name: _____
Date of Birth: _____
Phone Number to receive SMS messages / Phone Calls: _____
Email: _____

Signature: _____
Date: _____