PATIENT NAME:_____ **DOB:** ___/____/___ **CVTS HISTORY & PHYSICAL**

DATE OF VISIT: _____/_____/_____

REASON FOR YOUR VISIT TODAY: "_____
_____"

MEDICATIONS
List Drug Name, Dose, Frequency, Route
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.

ALLERGIES
List allergy and reaction
DO YOU HAVE A LATEX ALLERGY? ☐YES ☐NO
1.
2.
3.
4.
5.
6.
7.

DATE OF VISIT: _____/_____/_____

(Please fill out in detail)

MEDICAL PROBLEMS

CHECK ALL THAT APPLY:

☐Abdominal Aortic Aneurysm	☐Dementia	☐Irritable Bowel Syndrome
☐Alcoholism	☐Dental Cavities	☐Kidney Disease
☐Alzheimer's Disease	☐Depression	☐Liver Disease
☐Anemia	☐Diabetes, Insulin Dependent	☐Melanoma
☐Angina	☐Diabetes, Non Insulin Dependent	☐Migraines
☐Anxiety	☐Diabetes, Oral Medications	☐Mitral Valve Disease
☐Aortic Valve Disease	☐Diverticulosis	☐Myocardial Infarction (Heart Attack)
☐Arteriosclerosis	☐Emphysema	☐Obesity
☐Arthritis	☐Enlarged Prostate	☐Palpitations
☐Asthma	☐Epilepsy	☐Peptic Ulcer Disease
☐Atrial Fibrillation	☐Erectile Dysfunction	☐Peripheral Vascular Disease (PVD)
☐Atrial Flutter	☐Esophagitis	☐Physical Inactivity
☐Birth Defect	☐Fibromyalgia	☐Pneumonia
☐Black Lung	☐Gallbladder Disease	☐Poor Circulation
☐Bleeding Disorder	☐Gastric Ulcers	☐Positive TB Test
☐Blood Clots / Clotting Disorder	☐Gastroesophageal Reflux Disease	☐Pulmonary Embolism
☐Cancer Type:_____	☐Heart Failure	☐Rheumatic Fever
☐Cardiac Arrhythmia, Irregular Heart Beat	☐Heart Murmur	☐Scarlet Fever
☐Carotid Artery Stenosis	☐Heartburn	☐Seizure Disorder
☐Cataracts	☐Hepatitis	☐Sickle Cell Anemia
☐Cerebrovascular Accident (CVA)	☐Hernia, Abdominal	☐Sleep Apnea
☐Chickenpox	☐Hernia, Hiatal	☐Stroke
☐Chronic Obstructive Pulmonary Disease (COPD)	☐HIV / AIDS	☐Transient Ischemic Attack (TIA)
☐Crohn's Disease	☐Hypercholesterolemia, High Cholesterol	☐Trouble Urinating
☐Chronic Respiratory Infections	☐Hypertension, High Blood Pressure	☐Thyroid Disease
☐Colitis	☐Hyperthyroidism (high thyroid)	☐Tuberculosis
☐Constipation	☐Hypothyroidism (low thyroid)	☐Ulcer, Skin
☐Coronary Artery Disease (CAD)	☐Inhaler Use, Chronic	
☐Deep Vein Thrombosis	☐Iron Transfusions	

DATE OF VISIT: _____/_____/_____

SURGICAL HISTORY

Surgery Type, Year, Hospital:
1.
2.
3.
4.
5.

DO YOU HAVE A PACEMAKER OR AUTOMATIC IMPLANTABLE CARDIAC DEFIBRILLATOR? YES NO
IF YES, WHAT MAKE/MODEL:_____

ARE YOU CURRENTLY PREGNANT OR TRYING TO BECOME PREGNANT? YES NO

ANESTHESIA COMPLICATIONS

HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA? YES NO

IF YES, PLEASE DESCRIBE:

SPECIALISTS

PLEASE LIST ANY OTHER DOCTORS NAMES AND SPECIALITY THAT YOU SEE FOR MEDICAL CONDITIONS:
DOCTOR'S NAME SPECIALITY

ASSISTIVE DEVICES

DENTITION: ☐ Natural Teeth ☐ Partial Dentures ☐ Full Dentures

NAME OF DENTIST: _____

HAVE YOU SEEN YOUR DENTIST IN THE PAST SIX MONTHS? YES NO

DO YOU HAVE ANY LOOSE TEETH OR DENTAL CAVITIES WHICH HAVE NOT BEEN FIXED? YES NO (Please indicate which)

DATE OF VISIT: _____/_____/_____

(Please fill out in detail)

FAMILY HISTORY

Check all that apply:	Father	Mother	Brother1	Brother2	Brother3	Sister1	Sister2	Sister3
Anemia?								
Cancer? ****INDICATE CANCER TYPE****								
Diabetes?								
Heart Disease or Heart Attack?								
High Blood Pressure?								
Lung or Respiratory Disease?								
Stroke?								
Poor Circulation?								
Deceased/Cause of Death/Age at Death?								

(Please fill out in detail)

SOCIAL HISTORY

Marital Status ☐Divorced ☐Married ☐Never Married ☐Separated ☐Widowed

Living With? ☐Alone ☐Daughter ☐Other ☐Parent ☐Significant Other ☐Son ☐Spouse

Name: _____

Your Current/Past Occupation (or Prior to Retirement): _____

Currently Employed ? ☐YES ☐NO ☐Retired

Have you ever worked in?: ☐Boiler Room Ship ☐Brakes/Clutches ☐Construction ☐Demolition ☐Metal working ☐Navy Veteran ☐Paper Mill ☐Power Plant ☐Railroad Yard ☐Refinery ☐Steel Mill ☐Submarine ☐Toll Booth ☐Wood Working ☐None

Have you ever been exposed to?: ☐Arsenic ☐Asbestos ☐Beryllium ☐Cadmium ☐Chromium ☐Diesel Fumes ☐Nickel ☐Radiation ☐Radon ☐Second Hand Smoke ☐Silica ☐None

Have you ever lived in the Ohio-Mississippi River Valley or San Joaquin Valley? ☐YES ☐NO

Religious/Cultural Practices? If necessary, do you wish to receive Blood Products ☐YES ☐NO

(Please fill out in detail)

PERSONAL HABITS

Cigarette Smoking	☐ Never	☐ **Quit # _____ Years ago**	☐**Currently Smoking #_____packs/day**	X #_____ years
Cigar Smoking	☐ Never	☐ Quit # _____ Years ago	☐Currently Smoking #_____pipes/day	X #_____years
Pipe Smoking	☐ Never	☐ Quit # _____ Years ago	☐Currently Smoking #_____pipes/day	X #_____years
Smokeless Tobacco	☐ Never	☐ Quit # _____ Years ago	☐Currently Smoking #_____cans /day	X #_____years
Alcohol	☐ Never	☐ Quit # _____ Years ago	☐Occasionally	☐ Daily #_____ drinks/day
Street Drugs (list Name)	☐ Never	☐ Quit # _____ Years ago	☐Occasionally	☐ Currently #_____ times/day
Herbal Supplements	☐ No	☐ Yes, I take:_____		

DATE OF VISIT: _____/_____/_____

REVIEW OF SYSTEMS

PLEASE CHECK ANY PROBLEMS THAT YOU ARE CURRENTLY HAVING:

GENERAL:	**RESPIRATORY:**	**EXTREMITIES: Please indicate Right/Left**
☐Anxiety	☐Breathing difficulty (painful)	☐Cold extremities
☐Chills	☐Cough, frequent dry	☐Numbness/tingling
☐Fatigue	☐Cough, with sputum	☐Rest pain, leg
☐Fever	☐Congestion	☐Trouble walking, leg cramps
☐Not feeling well	☐Hemoptysis (coughing up blood)	**SKIN:**
☐Pain	☐Inhaler use, currently taking	☐Lesions
☐Weakness	☐Night sweats	☐Rash
☐Weight gain, unexplained	☐Oxygen use at home	☐Redness
☐Weight loss, unexplained	☐Shortness of breath with minimal activity	☐Sores
EYES:	☐Shortness of breath with stairs	**NERVOUS SYSTEM:**
☐Crossed eyes	☐Shortness of breath at rest	☐Aphasia – difficulty speaking
☐Vision, blurred	☐Snoring	☐Disorientation
☐Vision, doubled	☐Wheezing	☐Dizziness
CARDIAC:	**GASTRO-INTESTINAL:**	☐Headaches
☐Angina – chest pain at rest	☐Abdominal Swelling	☐Imbalance
☐Angina – chest pain with activity	☐Poor Appetite	☐Involuntary movements
☐Dizziness	☐Rectal Bleeding	☐Paralysis
☐Edema	☐Constipation	**PSYCHOLOGICAL/MENTAL:**
☐Faintness	☐Diarrhea	☐Claustrophobia
☐Fatigue	☐Dysphagia (Difficulty Swallowing)	☐Depression
☐Heart Racing	☐Heartburn	☐Paranoia
☐Irregular heartbeat	☐Indigestion	**ENDOCRINE:**
☐Lethargy	☐Nausea	☐Sweating, Excessive
☐Lightheadedness	☐Stool, bloody or tarry	☐Thirst, excessive
☐Nocturia (nighttime urination)	☐Vomiting	☐Urination, excessive
☐Orthopnea (sleeps with >1 pillow or in chair)	**GENITOURINARY:**	**HEMATOLOGIC PROBLEMS:**
☐Palpitations	☐Frequency	☐Anticoagulant Use
☐Poor Exercise Toleration	☐Hematuria (blood in urine)	☐Bleeds Easily
☐Swelling of feet/ankles	☐Retention	☐Bruises Easily
☐Swelling of hands		
☐Ulcers, non-healing		

Patient Name:_____ Medical Record # (if known):_____

Date of Birth:_____ Phone #: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. **The following individual or organization is authorized to make the use or disclosure:**
   (This is the holder of your information that you are telling to share it with someone else; example, Pinnacle Health System.)
   Name: PinnacleHealth Cardiovascular and Thoracic Surgery
   Address: 205 S Front Street, Harrisburg, PA 17104
3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):
   - ☐ History & Physical, Discharge Summary, Consult, Progress Note, Operative Report, X-rays, Lab — Dates: _____
   - ☐ Entire Record — Dates: _____
   - ☐ Other (specify) _____ — Dates: _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. ***The following information is protected by State and Federal Law. If this information applies to you, please indicate if you would like this information released/or obtained*** (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	_____ Yes _____ No	Dates:	_____
HIV Testing and Results	_____ Yes _____ No	Dates:	_____
Mental Health or Psychotherapy Records	_____ Yes _____ No	Dates:	_____

5. **This information may be disclosed to and used by the following individual or organization:**
   (This is who you want your information shared with or sent to; examples, your attorney or your family member.)

Name	Address	Reason for Release	Date	Type of Information
A				
B				
C				

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization is effective as of the date set forth below. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire 120 days from the date that I sign it.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that Pinnacle Health Hospitals may not condition treatment on whether I sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided by federal patient privacy regulations. I understand that any disclosure of information carries with it the potential for information disclosed pursuant to this authorization to be redisclosed by the recipient and no longer be protected by federal patient privacy regulations. If I have questions about this form, I may contact the Health Information Department, Release of Information office at 717-782-3293. If I have questions about disclosure of my health information, I may contact the Compliance and Privacy Officer at Pinnacle Health System, P.O. Box 8700, Harrisburg, PA 17105 or by phone at 717-231-8211.

_____ _____

Signature of Patient or Personal Representative — Date

_____ _____

If Signed by Personal Representative, Describe Personal Representative's Authority — Signature of Witness

PINNACLEHEALTH

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION - GENERAL

PATIENT IDENTIFICATION

IF A PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

Patient (is a minor_____years of age) or is unable to consent because:_____

_____

The above named patient is currently unable to provide a signature on this form.

_____ Date:_____

Signature of Parent, Legal Representative (legal guardian, executor or administrator of the estate)

Relationship to Patient: _____

Witness Signature: _____ Date:_____

ORAL CONSENT

Only For Persons Physically Unable to Provide a Signature
Whose Records are Being Released Pursuant to the Pennsylvania
Mental Health Procedures Act Regulations

I witnessed that_____ (patient's name) understood the nature of this release, understood that he/she may orally revoke this consent at any time except to the extent that action has been taken in reliance upon it and freely gave his/her oral consent.

_____ _____
Witness Date

_____ _____
Witness Date

PINNACLEHEALTH

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION - GENERAL

PATIENT IDENTIFICATION