The Chattanooga Heart Institute

Dear Patient:

Thank you for choosing The Chattanooga Heart Institute for your cardiac care. With 29 board-certified cardiologists, three cardiothoracic surgeons, three cardiovascular surgeons and 14 advanced practice providers, we offer a comprehensive, team approach to your care.

- Please fill out the attached forms and bring them with you to your appointment. In order for us to provide you with the best care possible, it's important that you fill out all forms completely.
- Please arrive 30 minutes prior to your appointment.
- It's important that you bring all medications in their original bottles or that you bring a detailed list with the name of the medication, the dosage and when you take each medication. Please also bring a list of any over-the-counter medications you take such as vitamin supplements, aspirin, etc. During your visits, please let the nurses know if you need a refill of a prescription.
- Bring your insurance card and a photo ID to each appointment.
- To protect your privacy, each time you call our office, you'll be asked your date of birth and the last four digits of your social security number. If someone calls on your behalf, please provide them with this information. This is to ensure that we are speaking only to someone whom you've asked to call on your behalf.

We look forward to seeing you! Please call us at (423) 697-2000 should you have any questions.

Physicians and staff
The Chattanooga Heart Institute

The Chattanooga Heart Institute

NEW PATIENT FORM

MR#: Date:

Name:_____
(Last) (First)

Marital Status: (circle one)
Married Divorced Single Widowed Life Partner

Age:_____ Date of Birth:_____

Occupation:_____
(if applicable)

Referring Physician:_____
(First) (Last)

Employer:_____

Primary Care Physician:_____
(First) (Last)

Do you have a living will or advance directive?
YES NO

Pharmacy:_____ Pharm. Address & Phone:_____

What type of problem led to your visit here today?_____

_____When did this start?_____

Quick Review of Systems: Are you currently experiencing any of the following symptoms? (please circle all that apply)

Chest pain	Visual changes	Memory loss
Heart fluttering or racing/palpitations	Hearing loss	Seizures
Excessive sweating/diaphoresis	Snoring	Depression
Passing out or fainting/syncope	Coughing up blood/hemoptysis	Hallucinations
Difficulty breathing lying down/orthopnea	Shortness of breath/dyspnea	Low blood count/anemia
Shortness of breath that wakes you up/PND	Feeling of sickness to the stomach/nausea	Low blood platelet count/thrombocytopenia
Pain in legs when walking/claudication	Heartburn/reflux	Thyroid enlarged/goiter
Ankle or leg swelling/edema	Bleeding	Tremors
Weight gain	Blood in urine/hematuria	Rash
Weight loss	Waking up at night to urinate/nocturia	Skin sores
Fever	Dizziness	Joint pain
		Muscle cramps/pain/myalgia

Past Medical History: (please circle all that apply)

Anemia	Coronary Artery Disease	Aneurysm - if yes, location:
Blood Clots	Diabetes	_____
Cardiac Arrhythmia	Elevated Cholesterol	Heart Valve Disease
Cardiovascular Disease	Hypertension	Congestive Heart Failure
Carotid Artery Stenosis	Myocardial Infarction	Stroke
COPD	Renal Disease	TIA

Other:_____

Past Surgical History: (please circle all that apply)

Angioplasty	Dialysis	EP Study/Ablation
CABG/Heart Bypass	ICD/Defibrillator Insertion	Arteriogram/Heart Cath/Stent
Cardiac Pacemaker	Heart Valve Surgery	Vascular Surgery

Other surgeries:_____

Date:_____ Provider Signature:_____

Patient Name: MR #: Date:

Diagnostic Studies: (please circle all that apply)

Echocardiogram	Treadmill Test	Holter Monitor
CT/CTA	Nuclear Stress Test	EP Study
Vascular Ultrasound		

Family History: (please circle all that apply)

1. If your relative listed below had the condition, please enter their age when it started in the box.

2. If you don't know how old they were when it began, just place a check mark in the box.

3. Enter your relatives current age or age at death in the last column.

	Abnormal Heart Rhythm	Heart Failure	Heart Attack or Surgery	Sudden Death	High Cholesterol	High Blood Pressure	Diabetes	Current Age	Cause of death	Age at Death
Father										
Mother										
Brother #1										
Brother #2										
Brother #3										
Sister #1										
Sister #2										
Sister #3										

Social History:

Do you smoke? ☐ No/Never ☐ Yes or Former Age started:_____ ☐ Daily Use # per day? _____

Age stopped:_____ (if applicable)

☐ Cigarette ☐ Cigarillo ☐ Cigar ☐ Pipe ☐ Smokeless ☐ Snuff ☐ Vapor/Electric

Do you drink alcohol? ☐ No ☐ Yes Type:_____ How often: _____

Amount: _____ Last drink:_____

Do you consume caffeine? ☐ No If yes, how much do you consume per day?_____

☐ Yes ☐ Coffee ☐ Soda ☐ Energy drink ☐ Chocolate

Do you exercise? ☐ No Type of exercise: _____

☐ Yes Hours per week: _____

Date:_____ Provider Signature:_____

Patient Name: MR #: Date:

Allergies:

☐ Contrast Dye ☐ Latex Allergy ☐ No Known Allergies

☐ Any medication allergies: _____

_____

Medications:

Medication Name	Dose	Times per day

_____

Patient Signature

_____

Date

_____

Provider Signature

_____

Date

_____

Print Provider Name