Live Oak Cardiology PA
155 Cimarron Park Loop Suit A
Buda, Texas 78610
Phone: 1-512-295-5888 Fax: 1-512-295-2282

Patient Information Form

Name: _____
Last **First** **Middle**

Address: _____
Street **Apt#** **City** **State** **Zip Code**

Phone #'s: _____
Home **Work** **Cell/Other**

Employer Name: _____ **Employer Number:** _____

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

DOB: _____ **Last 4 of Social Security Card:** _____ **Sex:** Male/Female **Marital Status:** S/M/D/W

Primary Care Physician: _____ **Phone#:** _____

Primary Insurance Information

Insurance Company: _____ **ID #:** _____ **Group#:** _____

Insurance Claim Address: _____ **Insurance Phone#:** _____

If you are not the policy holder, please fill out the information below!

Policy Holder's Name: _____

DOB: _____ **Relationship to Patient:** _____

Secondary Insurance Information

Insurance Company: _____ **ID#:** _____ **Group#:** _____

Insurance Claim Address: _____ **Insurance Phone#:** _____

If you are not the policy holder, please fill out the information below!

Policy Holder's Name: _____

DOB: _____ **Relationship to Patient:** _____

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Patient Name _____ **Date of Birth** _____

Address _____ **Telephone Number** _____

I do hereby Authorize _____ to disclose the above-named individual's health information

I authorize the release of...
□ **Office notes** □ **Imaging (EKG, ULTRASOUND)** □ **Labs**

Date of Service _____ (mm/yyyy) to Ending Date of Service _____ (mm/yyyy)

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to the following individual organization:

Live Oak Cardiology	155 Cimarron Park Loop	Buda	Texas/78610
Name (facility receiving information)	**Address**	**City**	**State/Zip**

Phone: (512) 295-2558 Fax: (512) 295-2282
****Phone / Fax Number****

I understand that this authorization is voluntary and I may refuse to sign this release. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed and that information used of disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. Live Oak Cardiology may charge a processing fee for this service. This authorization will be in effect until _____ (date or event). If no date given, release will remain active.

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Live Oak Cardiology. If I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation

Signature of Patient or Patient's Representative _____ **Date** _____

Printed Name _____ **Relationship to Patient** _____

LIVE OAK CARDIOLOGY

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Cardiology History Form

Name:_____ Date:_____

Referring Physician:_____ Date of Birth: _____

Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for you

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain with activity		Burning or painful urination	
Recent weight change		Heart skips beats		Frequent urination	
Fatigue		Heart beats too fast		Blood in urine	
Heat or cold intolerance		Passing out spells		Bladder infections	
Head and Neck	**YES**	High blood pressure		Incontinence, dribbling	
Swelling in neck		Heart murmur		Kidney stones	
Prolonged hoarseness		Bad heart valve		Change in stream	
Sore throat		Rheumatic Fever		Irregular menses, female only	
Pain or stiffness in neck		Feet or ankle swelling		**Gastrointestinal**	**YES**
Skin	**YES**	Short of breath at rest		Rectal bleeding	
Rash, dryness, itching		Short of breath with exercise		Blood in stool	
Change in nails or skin color		Short of breath lying down		Loss of appetite	
Bleeding, bruising tendencies		**Lungs**	**YES**	Heartburn or indigestion	
Eyes	**YES**	Cough		Chronic abdominal pain	
Glasses or contacts		Cough with sputum or blood		Chronic constipation	
Double, failing vision		Wheezing		Black or tarry stools	
Dry eyes		**Musculoskeletal**	**YES**	Frequent diarrhea	
Pain or light sensitivity		Swollen or red joints		Difficulty swallowing	
Ears, Nose, Mouth	**YES**	Arm or leg weakness		Nausea or vomiting	
Loss of smell		Leg cramps		Vomiting of blood	
Nose bleeds		Difficulty in walking		**Endocrine**	**YES**
Sinus problems		**Neurologic**	**YES**	Night sweats	
Runny nose		Light headed or dizziness		Excessive thirst	
Postnasal drip		Speech disturbances		**Psychiatric**	**YES**
Earache or drainage		Convulsions or seizures		Depression	
Hearing loss		Numbness or tingling		Anxiety	
Ringing in ears		Frequent headaches		Nervous breakdown	
Dentures		Memory loss		Alcohol problems	
Sores in mouth		Paralysis or weakness		Physical, verbal, sexual abuse	
		Sleep disorders		Drug problems	

Past and Family Medical History: Please check if you or your families have ever had any of the following

	You	Family		You	Family		You	Family
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Blood Disorders			Vision Problems		
Renal Disease			Lupus			Hearing Problems		
Ulcerative Colitis			Stroke			Glaucoma		
Other			Other			Other		

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Please list all of your medications, including over the counter medications, vitamins or supplements (if you need more space please write it on another sheet of paper)

Name of Medication	Dosage	Number of Times Per Day	Reason for Medication

Please list all allergies including medications, food, and environmental

Medication, Food, Other	Reaction

Please list any recent hospitalizations, and surgeries, and an approximate date of hospitalization

Date	Reason for hospitalization or surgery

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Social History:

Marital Status:Single ❑ Divorced ❑ Married ❑ Widow/Widower ❑ Other ❑

Who lives at home with you? _____

How many children? _____

Emergency contact name and phone number: _____

Current Occupation/Employer:_____ Type of work:_____

General stress level: LOW/MEDEUIM/HIGH

Are you on a specific diet? If so, please specify:_____

What is your exercise level? Occasional/ Moderate / Heavy

Do you smoke? Yes ❑ No ❑ If yes, how many cigarettes per day?

How many years have you been smoking _____?

If you quit smoking, how long has it been since your last cigarette? _____

Have you ever used Chewing Tobacco? _____

Do you use a Vape or e-cigarettes? Yes □ No□ It yes, how often do you use it? _____

Do you drink alcohol? Yes ❑ No ❑

If yes, indicate on average how much. Per day: _____ Per Week: _____

Do you use illegal drugs? Yes ☐ No ☐

If yes, please provide name and when last used. _____

Do you have an advance directive? Yes☐ No☐

Are you hard of hearing? Yes ☐ No ☐ Are you legally blind? Yes ☐ No ☐

Do you have Difficulty concentrating, remembering or making decisions? Yes ☐ No ☐

Are you having difficulty doing errands alone? Yes □ No □

Are you having Difficulty dressing or bathing? Yes □ No □

Are you having Difficulty walking or climbing stairs? Yes □ No □

In this box you can list any other additional information you want to let our staff know?