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**Excelsior Springs Office**  
1700 Rainbow Dr.  
Excelsior Springs, MO 64024

**Ray County Office**  
904 Wollard Blvd.  
Richmond, MO 64085

### **INFORMATION FOR YOUR PHYSICIAN**

The following questions will help your physician to know your health and previous health problems. The health of your relatives often affects your own health, so please give those answers to the best of your knowledge.

Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Alternate Daytime Phone: \_\_\_\_\_

*Check the main reason you are coming to the cardiologist (heart doctor) and to the best of your ability, explain in your own words.*

\_\_\_\_\_ **Chest pain (such as chest pressure, tightness, burning in the chest, heaviness)**

- With exertion (such as with walking, climbing stairs)
- At rest (such as with emotional upset, stress)
- Awakens from sleep

*Explain your chest pain in your own words:*

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **Shortness of breath (can't get air)**

- With exertion (such as walking, climbing stairs)
- Awakens you from sleep (have to sit up to breath)
- Have to sleep on more than one pillow to breath

*Explain your shortness of breath in your own words:*

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Palpitations (heart races, heart beats too fast, heart skips beats)

\_\_\_\_\_ Syncope (passing out, nearly passing out, losing consciousness)

\_\_\_\_\_ Hypertension (high blood pressure)

\_\_\_\_\_ Heart murmur (leaking heart valve)

\_\_\_\_\_ Pedal edema (legs swelling)

\_\_\_\_\_ Rheumatic fever

\_\_\_\_\_ Cardiac catheterization (heart cath, heart angiogram)

\_\_\_\_\_ Balloon angioplasty and/or stent

When? \_\_\_\_\_

Where? \_\_\_\_\_





**SOCIAL HISTORY**

Marital Status:  Married  Single  Separated  Divorced  Widow  Widower

Religious Preference: \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_ Age on completion: \_\_\_\_\_

Occupation (If retired, list former occupation) \_\_\_\_\_ Length? \_\_\_\_\_

When and where have you lived or traveled outside the U. S.?  
\_\_\_\_\_  
\_\_\_\_\_

Place of Birth: \_\_\_\_\_ Race or nationality parents: \_\_\_\_\_

Do you use any form of tobacco now?  Yes  No If yes, answer questions below.

Cigarettes  Cigars  Pipe  Chewing Tobacco Daily Amount: \_\_\_\_\_

Have you used tobacco in the past?  Yes  No

If yes, when did you quit? Year: \_\_\_\_\_ How many years? \_\_\_\_\_

Type and Daily Amounts: \_\_\_\_\_

Do you use alcoholic beverages?  Yes  No

If yes, type and weekly amount: \_\_\_\_\_

**Other Notes:**

Please check any of the following problems you have now or had in the past:

<b>Constitutional:</b> <input type="checkbox"/> Recent Change in Weight Increase _____lbs Decrease _____lbs <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Fever/Chills/Sweats <input type="checkbox"/> Fatigue  <input type="checkbox"/> N/A	<b>Cardiovascular:</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of Air <input type="checkbox"/> Stroke <input type="checkbox"/> Syncope (Fainting) <input type="checkbox"/> Swelling Feet/Hands  <input type="checkbox"/> N/A	<b>Muscoskeletal:</b> <input type="checkbox"/> Joint/Muscle Pain <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Joint Stiffness/Swelling <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back Problems <input type="checkbox"/> Limitation of Movement  <input type="checkbox"/> N/A
<b>Endocrine:</b> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Urination  <input type="checkbox"/> N/A	<b>Genitourinary:</b> <input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Urinary Infections  <input type="checkbox"/> N/A	<b>Neurological:</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Paralysis <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Headaches <input type="checkbox"/> History of Head Injury <input type="checkbox"/> Difficulty with Balance  <input type="checkbox"/> N/A
<b>Ears/ Nose/Mouth/Throat:</b> <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Aids <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Hoarseness <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Difficulty with Teeth <input type="checkbox"/> Dentures  <input type="checkbox"/> N/A	<b>Eyes:</b> <input type="checkbox"/> Difficulty with Vision <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye Injury  <input type="checkbox"/> N/A	<b>Respiratory:</b> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Coughing up Blood  <input type="checkbox"/> N/A
<b>Skin:</b> <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Hives <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Lumps  <input type="checkbox"/> N/A	<b>Gastrointestinal:</b> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Colitis <input type="checkbox"/> Black Bowel Movements  <input type="checkbox"/> N/A	<b>Other:</b>

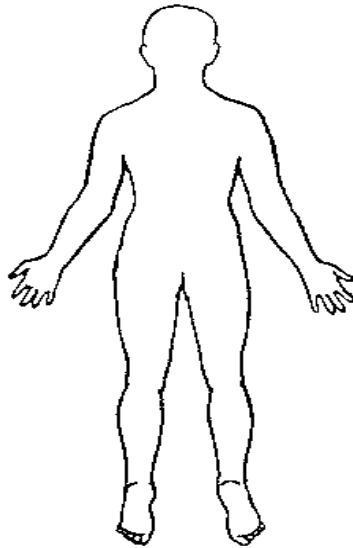
Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

(Physician Signature)

<b>Patient Name:</b>	<b>DOB:</b>	<b>Date:</b>
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**Peripheral Vascular Disease (PVD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrow or clogged. Please fill out this questionnaire to see if you have symptoms of Peripheral Vascular Disease.**

- |    |  |            |           |
|----|--|------------|-----------|
| 1. | When you walk or exercise, do you experience aching, cramping, or pain in your arms, legs, thighs, or buttocks?                      | <b>Yes</b> | <b>No</b> |
| 2. | If this pain occurs when you are walking, does it limit your ability to perform your normal day's activities?                        | <b>Yes</b> | <b>No</b> |
| 3. | Do you suffer from pain in your legs while at rest?<br>If yes, circle the area of the body on the diagram below where you feel pain. | <b>Yes</b> | <b>No</b> |



- |    |  |            |           |
|----|--|------------|-----------|
| 4. | Do you have any painful sores or ulcers on your legs or feet that are not healing? | <b>Yes</b> | <b>No</b> |
|----|--|------------|-----------|

If you answered "yes" to any of the above questions, you may be at risk for PVD.

**Physician Only:**

- ABI - Lower Extremity Non-Invasive Vascular Evaluation
- CTA if Cr OK
- Patient Already Receiving Treatment
- Patient Not a Candidate for Further Screening

**Notes:**

Physician: \_\_\_\_\_

**ICD9 Codes**

**Peripheral Vascular Disease**

- 440.0 Aorta
- 440.20 Extremities, Unspecified
- 440.21 Extremities, Intermittent Claudication
- 440.22 Extremities, with Rest Pain
- 440.23 Extremities, with Ulceration

**Other Signs/Symptoms**

- 729.5 Limb Pain
- 785.9 Weak Pulse
- 785.9 Arterial Bruit
- Other \_\_\_\_\_
- Other \_\_\_\_\_