Regional Heart Center Cardiology
Dr. David Aliabadi

Section 1: Patient Information

Date: _____ **Social Security #:** _____-_____-_____

First Name: _____ **MI:**_____ **Last:** _____

Preferred Name: _____ **Email:** _____

Date of Birth: _____ **Sex: M**__ **F**___ **Marital Status: Married**___ **Single** ___ **Divorced** ___ **Widowed** ___

Address: _____ **Home Phone:** (____)_____

_____ **Cell Phone:** (____)_____

City: _____ **St:**___ **Zip:** _____ **Work Phone:** (____)_____

Employed: _____ **Retired:** _____ **Other:** _____

Employer: _____ **Occupation:** _____

Referring Physician: _____

Chief Complaint: _____

Section 2: Primary Insurance Information

Commercial: _____ **Medicare:** _____ **Work Comp:** _____ **Other:** _____

Insurance Company: _____

Policy #: _____ **Group #:** _____

Secondary Insurance Information:

Commercial: _____ **Medicare:** _____ **Work Comp:** _____ **Other:** _____

Insurance Company: _____

Policy #: _____ **Group #:** _____

Guarantor/Responsible Party

First Name: _____ **Last Name:** _____ **Sex:** _____

Date of Birth: _____ **Relationship:** _____

Section 3: Emergency Contact

First Name: _____ **Phone #:** (____)_____

Last Name: _____ **Alternate #:** (____)_____

Relationship: _____

Section 4: Medical Assignment of Benefits and Release of Information Authorization

I hereby authorize David Aliabadi, M.D., to release any information requested by my insurance company regarding treatment of the undersigned or my dependent. I authorize payment directly to the above named physician of any insurance payments or benefits otherwise payable to me. This is to include any major medical benefits, in addition to basic benefits payable. I understand that I am responsible for any portion of the bill not covered by insurance and I agree to pay in full at time of service

Signature: _____ **Date:** _____

Regional Heart Center Cardiology
2220 Lynn Road, Suite 203
Thousand Oaks, CA 91360

HIPAA Release Form

Patient Name:_____

Patient DOB:_____

I,_____, hereby authorize **Regional Heart Center** to share my confidential health information to the following person(s) or organization(s):

- ❑ Spouse/SO: _____
- ❑ Child(ren): _____
- ❑ Parent(s): _____
- ❑ Doctor(s) _____
- ❑ Other: _____
- ❑ May not be released to anyone

I authorize the release of the following information:

- ❑ All health information pertaining to my medical history, mental or physical condition and treatment received; OR
- ❑ All health information except for the following:
  - __ Mental health records
  - __ HIV test results
  - __ Alcohol/drug abuse treatment records
  - __ Genetic information
  - __ Other (specify): _____

I understand that:

- Failure to sign this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.
- I do not need to give any further permission for the my health information detailed above to be shared with the person(s) listed above.

Signature:_____ **Date:**_____

REGIONAL HEART CENTER OF THOUSAND OAKS
2220 Lynn Rd, Thousand Oaks, CA 91360

Richard M Green, MD
Martin A Josephson, MD

John Y Hess, MD
David Aliabadi, MD

CONFIDENTIAL QUESTIONARE

Name, Last:_____ First:_____ Middle:_____ Age:____

Date of Appointment:_____

Family Physician:_____ Referred by:_____

Occupation:_____

Describe briefly the reason you were referred to or are seeking the services of a cardiologist:

_____

_____

_____

_____

_____

Symptoms:_____

Do you have chest pain? Yes:_____ No:_____ In the past, yes:_____

If yes, what brings on the chest pain?_____

In what part of your chest is the pain located?_____

How long does a typical episode last?_____ ,seconds:____, minutes:_____, hours:_____, all day:_____

Is the pain aggravated by meals? Yes:_____, No:_____

Does the pain go into the shoulder, arm or neck? Yes:_____, No:_____

Does exercise cause the pain? Yes:_____, No:_____

Does excitement make the pain worse? Yes:_____, No:_____

Does emotional stress make the pain worse? Yes:_____, No:_____

What can make the pain improve?_____

Do you notice palpitations or heart racing? Yes:_____, No:_____, In the past, yes:_____

Is dizziness a common problem? Yes:_____, No:_____, In the past, yes:_____

Have you had fainting or "black-out" spells? Yes:_____, No:_____, In the past, yes:_____

Do you notice shortness of breath when you are not exerting yourself: Yes:_____, No:_____, In the past, yes:_____

Do you have foot or ankle swelling? Yes:_____, No:_____, In the past, yes:_____

Have you ever been told you have a "heart murmur"? Yes:_____, No:_____

Do you often wake up during the night? Yes:_____, No:_____

If you wake up:

Are you short of breath? Yes:_____, No:_____, In the past, yes:_____

Do you have to urinate? Yes:_____, No:_____, In the past, yes:_____

Do you wake up because of chest pain? Yes:_____, No:_____

On how many pillows do you sleep?_____

Do you have leg cramps when walking? Yes:_____, No:_____

REGIONAL HEART CENTER OF THOUSAND OAKS

2220 Lynn Rd, Thousand Oaks, CA 91360

Name, Last:_____ First:_____

Risk Factors for Coronary Heart Disease:

Has either of your parents or any of your siblings had a heart attack? Yes:_____, No:_____, Unsure:____

If yes, relationship and approximate age at the time of ***first*** diagnosis of a heart condition:

1:_____ 2:_____

Has either of your parents or any of your siblings had a stroke? Yes:_____, No:_____, Unsure:_____

If yes, relationship and approximate age at the time of ***first*** stroke:

1:_____ 2:_____

Have you ever been told by a physician that you have diabetes? Yes:_____, No:_____

Have you ever been told by a physician that you have pre-diabetes? Yes:_____, No:_____

Has either of your parents or siblings had diabetes? Yes:_____, No:_____, Unsure:_____

If yes, relationship and approximate age when ***first*** diagnosed:

1:_____ 2:_____

Have you ever been told by a physician you have high blood pressure? Yes:_____, No:_____

If yes: Approximate the highest recording of which you are aware:_____

Are you taking medication for hypertension? Yes:_____, No:_____

Medication names and dosages:_____

Have you ever been told of an elevated "cholesterol" or "triglyceride" level? Yes:_____, No:_____

If available specific levels of:

Total Cholesterol:_____, Triglycerides:_____, HDL:_____, LDL :_____

Do you smoke? Yes:_____, No:_____,

If yes, how many cigarettes per day?_____, Age when starting?_____

If no, did you smoke in the past? Yes:_____, No:_____, How much?_____, Age when stopping:_____

Do you consider your job to be "high pressure"? Yes:_____, No:_____

Do you have frequent deadlines to meet? Yes:_____, No:_____

Do you enjoy your job? Yes:_____, No:_____

Do you have "gout" or elevated "uric acid"? Yes:_____, No:_____

Do you exercise regularly? Yes:_____, No:_____

Physical activities:_____

Do you consider yourself to be a "perfectionist"? Yes:_____, No:_____

Are you "compulsive" about relatively unimportant details? Yes:_____, No:_____

Do you consider yourself to be overweight? Yes:_____, No:_____, by how many pounds:_____

Females only: Last menstrual period?_____

Do you take birth control pills? Yes:_____, No:_____, if yes, what kind?_____

Are you on any hormone replacement therapy? Yes:_____, No:_____, if yes, what kind?_____

REGIONAL HEART CENTER OF THOUSAND OAKS
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Name, Last:_____ First:_____

Past Medical History: Have you had in the past:

Arthritis: Yes_____, No_____, Yes (in the past): _____

Asthma: Yes_____, No_____, Yes (in the past): _____

Blood in stool: Yes_____, No_____, Yes (in the past): _____

Gallstones: Yes_____, No_____, Yes (in the past): _____

Heartburn / indigestion: Yes_____, No_____, Yes (in the past): _____

Hepatitis: Yes_____, No_____, Yes (in the past): _____

Rheumatic Fever: Yes_____, No_____, Yes (in the past): _____

Stroke: Yes_____, No_____, Yes (in the past): _____

Thyroid Condition: Yes_____, No_____, Yes (in the past): _____

Tumors or Cancer: Yes_____, No_____, Yes (in the past): _____

Ulcers: Yes_____, No_____, Yes (in the past): _____

List past serious illnesses, surgery injury or hospitalizations:

(Hospital) (Illness, surgery, etc.) (Physician) (Year)

1_____
2_____
3_____
4_____
5_____

Medications, Social History, Habits:

Please list current medications and dosages:

1_____ 2_____
3_____ 4_____
5_____ 6_____
7_____ 8_____

Are you allergic to any medications? No_____, Yes_____, which ones?_____

Do you drink alcohol? Yes_____, No_____, if yes approx. amount each day:_____, week:_____

Which alcoholic beverages do you most consume?_____

Do you drink coffee? Yes_____, No_____, if yes approx. amount each day:_____

Religion (optional to respond):_____

Marital status: Single:_____, Married:_____, Widowed:_____, Separated:_____, Divorced:_____

Family History:

(Relation)	(Current age)	(State of Health)	(if deceased, approx age and cause of death)
1 Father			
2 Mother			
3 Brother(s)			
4			
5 Sister(s)			
6			
7 Children			
8			
9			
10 Spouse			