Department of Internal Medicine
Division of Cardiology

APPOINTMENTS: (813) 259-0600
TOLL FREE: (888) USF-DOCS
WEB: www.usfdocs.com

Provider: _____
Appt. Date: _____
Appt. Time: _____

We1come to the University of South Florida Heart Center!

The information regarding your appointment is listed above. For your convenience, we have enclosed a Cardiology Questionnaire and a map to the University of South Florida Medical Clinic, which indicates our complimentary valet service.

We are committed to working closely with your referring provider to aid you in the referral process. Prior to your appointment, we will request the medical records pertaining to your visit from your referring provider. After the visit, we will send the referring provider a report of your visit.

Coming to the appointment prepared enables you and your provider to make the best use of your time. An EKG maybe required for your visit. A new patient should arrive 30 minutes prior to his/her scheduled appointment time in order to complete the registration process and an EKG if necessary. Please remember to bring the following information with you when you come for your appointment:

- Your insurance card or policy
- The completed Cardiology Questionnaire (attached)
- Your EKG results, especially if the EKG was performed within 30 days of your appointment
- All other pertinent records and test results (i.e. treadmill, nuclear medicine, holter monitor, event monitor, cardiac catherization, angioplasty, etc.)
- Your medication bottles so that we may accurately list all medications that you are currently taking.

The above information is vital for the providers to provide quality care. Your provider may not be able to see you if you arrive for your appointment without these documents.

If you carry an HMO insurance policy, you are responsible for contacting your primary care physician and obtaining your referra1. We will be unable to see you without proper authorization.

If you are unable to keep your appointment, a 48-hour cancellation notice is appreciated.

Part of the USF mission is to teach the next generation of health care providers in an environment that fosters excellence in education, research, and compassionate patient care. Because we are an academic medical group, our faculty providers lead patient care teams that may include medical students, residents, fellows, and other health care providers. The providers you may encounter on your visit are as follows:

Medical Students: Students training to become physicians through a four-year course of study for a medical degree at the USF College of Medicine.

- Residents: Physicians training for a certain surgical specialty.
- Fellows: Physicians who have typically gone beyond residency training and are continuing their studies in a subspecialty area of their field.
- Physician Assistants (PA): A physician assistant is trained and qualified through advanced training to assume some of the duties and responsibilities formerly assumed only by a physician.
- Advanced Registered Nurse Practitioner (ARNP): A registered nurse who is qualified through advanced training to assume some of the duties and responsibilities formerly assumed only by a physician.

As a patient, you help us to educate tomorrow's health care providers while gaining access to the latest knowledge and advances in medicine. We appreciate your cooperation with our teaching efforts.

Thank you very much for choosing the University of South Florida Heart Center and we look forward to seeing you.

Sincerely,

USF Heart Center
Providers and Staff

USF HEART CENTER CARDIOLOGY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Age _____ Occupation _____

Marital Status: _____ Single _____ Married _____ Widower/Widow

Where were you born _____ Level of Education _____

Why were you referred for a cardiac evaluation? _____

PAST MEDICAL HISTORY:
Have you ever had or been treated for the following diseases:

Rheumatic Fever — If yes, at what age? _____

Heart Murmur — What year was this first noted? _____

Heart Attack — Dates _____

High Cholesterol — How many years _____ Level _____

High Triglycerides — How many years _____ Level _____

High Blood Pressure — How many years _____

Diabetes — How many years _____
Controlled by: Diet Pills Insulin

Have you ever had the following tests performed:

Heart Catheterization — Dates _____ Place _____

Angioplasty — Dates _____ Place _____

Heart Surgeries — Dates _____ Place _____

Treadmill — Dates _____ Place _____

Echocardiogram — Dates _____ Place _____

Thallium — Dates _____ Place _____

Other Cardiac Studies
(M U GA, etc.) _____

PREVIOUS SURGERIES:

Type of Surgery	Place	Date

ALLERGIES:

Drug or other	Reactions

MAJOR ILLNESS OR INURIES:

Reason for Admission	Place	Date

HABITS:

Do you or have you ever smoked or chewed tobacco? _____ Yes _____ No

If yes:

Cigarettes ____ Yes ____ No ___ pack/day for _____ years Date Stopped _____

Cigars ____ Yes ____ No ___ per day for _____ years Date Stopped _____

Pipe _____ Yes ____ No _____ years Date Stopped _____

Chewing _____ Yes _____ No _____ years Date Stopped _____

Snuff _____ Yes _____ No _____ years Date Stopped _____

Do you or have you ever consumed alcohol? _____ Yes _____ No

If yes: Casual Daily Excessive Amount _____

Caffeine: Casual Daily Excessive Amount _____

Any type of special diet required: _____

Exercise: _____ times per week

List below all medications, vitamins, laxatives. etc., that you have taken regularly during the past month. If the name of the medications is not known, please find the name from your pharmacist. Bring all medications with you.

Name (if known)	Purpose Taken	How often taken If daily how many per day

FAMILY HISTORY

Mother:

If living: Her age _____ years

History of heart disease: _____ Yes _____ No

If yes: What age diagnosed: _____

Health: _____

If deceased: Age at death _____ years

Cause: _____

Father:

If living: His age _____ years

History of heart disease: _____ Yes _____ No

If yes: What age diagnosed: _____

Health: _____

If deceased: Age at death _____ years

Cause: _____

LIVING: Brother or Sister

Age _____ Sex _____ Health _____
Heart Disease Yes _____ No _____ What age diagnosed? _____

Age _____ Sex _____ Health _____
Heart Disease Yes _____ No _____ What age diagnosed? _____

Age _____ Sex _____ Health _____
Heart Disease Yes _____ No _____ What age diagnosed? _____

Age _____ Sex _____ Health _____
Heart Disease Yes _____ No _____ What age diagnosed? _____

Age _____ Sex _____ Health _____
Heart Disease Yes _____ No _____ What age diagnosed? _____

Do you have problems with any of the following? (If YES, please give a brief description)

____ Syncope (fainting spells) _____

____ Indigestion _____

____ Cough _____

____ Weight Change _____

____ Headache _____

____ Nervousness _____

____ Eyes, Ears, Nose, and Throat _____

____ Other _____

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date