



Paul G. Hovsepian, M.D.
11 E. Adams Ave.
Alhambra, CA 91801

PATIENT INFORMATION FORM

Date: _____

Patient's Name: (last) _____ (first) _____ (middle) _____

Alternate name: _____ Sex: ☐ Male ☐ Female
(If different from above)

Street Address: _____
(Include apt/suite number)

City: _____ State: _____ Zip code: _____

Telephone (home): (____) _____ - _____ Telephone (other): (____) _____ - _____

Date of birth: _____ Social security #: _____ - _____ - _____

Primary Care Physician: _____

Marital status: ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Separated

Spouse/partner's name: _____ Spouse/partner's DOB: _____

Spouse/Partner's Social security #: _____ - _____ - _____

Emergency contact information:		
Name:	Telephone:	Relationship:
Name:	Telephone:	Relationship:
Name:	Telephone:	Relationship:

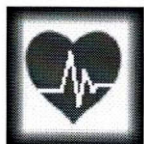
Insurance information:		
1.Primary Insurance Carrier:	Primary Insurance Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Primary Insurance Phone #	Policy and/or Subscriber ID #	Group #
2.Secondary Insurance Carrier:	Secondary Insurance Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Secondary Insurance Phone #	Policy and/or Subscriber ID #	Group #

3.Tertiary Insurance Carrier:	Tertiary Insurance Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Tertiary Insurance Phone #	Policy and/or Subscriber ID #	Group #

Work or Auto Injury? ☐ Yes ☐ No	Do you have an attorney ☐ Yes ☐ No	If yes, list attorney and/or W/C adjustor's name and phone #
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BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT.

Signature of Patient or Patient Representative:	Date signed:
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NEW PATIENT HISTORY

Date: _____ Referring MD: _____
Patient: _____ Reason For Your Visit: _____
DOB: ____/____/____ Age: _____ Sex: M F
Medication Allergies: _____
Pharmacy: _____ Date of Symptom(s) Onset: _____

**** SELECT YES IF YOU HAVE EVER HAD ****

CARDIAC PROCEDURAL HISTORY

- | | |
|--|--------|
| 1. Heart Attack | YES NO |
| If yes, when? _____ | |
| 2. Coronary Angiogram or
balloon/stent procedure? | YES NO |
| If yes, when? _____ | |
| 3. Heart Surgery? | YES NO |
| If yes, type: _____ when: _____ | |
| 4. Echocardiogram? (ultrasound of heart) | YES NO |

VASCULAR PROCEDURAL HISTORY

- | | |
|---|--------|
| 1. Pain in calves/thighs/buttocks while
walking? | YES NO |
| How far do you walk prior to pain? _____ | |
| 2. Any sores on legs/feet? | YES NO |
| 3. Previous surgery on arteries?
(legs, abdomen, neck) | YES NO |
| 4. Aneurysm? (ballooning of artery) | YES NO |
| 5. Carotid Doppler?
(ultrasound of arteries of neck) | YES NO |
| 6. Arterial Doppler? (leg circulation
test) | YES NO |

CARDIOVASCULAR RISK FACTOR SURVEY

- | | | | |
|-------------------------------|--------|--|--------|
| 1. Do you smoke/chew tobacco? | YES NO | 3. Do you have a history of Peripheral Vascular Disease? | YES NO |
| Have you in the past? | YES NO | 4. Do you have a history of high blood pressure? | YES NO |
| a. Packs/day? _____ | | How long? _____ | |
| b. Years smoked? _____ | | 5. Do you have a history of high blood cholesterol? | YES NO |
| a. Packs/day? _____ | | 6. Is there a family history of... <i>Please list relationship</i> | |
| 2. Are you diabetic? | YES NO | a. Heart Disease? _____ | YES NO |
| Type 1 or Type 2? _____ | | b. Diabetes? _____ | YES NO |
| How long? _____ | | c. Cancer? _____ | YES NO |
| | | d. Stroke? _____ | YES NO |

PAST MEDICAL HISTORY*Previous Surgeries and Chronic Conditions*

<u>Type</u>	<u>Date</u>
1. History of Stroke?	YES NO
2. Any lung disease? (COPD, Asthma)	YES NO
3. Any GI Issues? (PUD, cirrhosis)	YES NO
4. Any blood disorders? (anemia)	YES NO
5. Are you on Dialysis?	YES NO
6. History of cancer?	YES NO
7. _____	
8. _____	
9. _____	
10. _____	
11. _____	
12. _____	
13. _____	
14. _____	
15. _____	
16. _____	

SOCIAL HISTORY/HABITS

(Circle Selection)

Marital Status:	Single	Divorced	Life Partner
	Married	Widowed	Unknown
Children:	YES	NO	
Caffeine Status	YES	NO	
Types (select 2):	Coffee	Chocolate	Tablets
	Soda	Tea	
Alcohol Status:	Current	Never	Former
Year Quit:	_____		
Frequency:	_____		
Drug Use/Abuse Status:	Current	Never	Former
Year Quit:	_____		
Type:	_____		
Frequency:	_____		
Route:	_____		
Primary Language:	English or _____		
Race:	_____ or Decline		
Ethnicity:	_____ or Decline		

REVIEW OF SYMPTOMS*(Check all that apply)*

Cardiac	☐ Chest Pain	☐ Diaphoresis (<i>sweating</i>)	☐ Orthopnea (<i>difficulty breathing while laying down</i>)
	☐ Palpitation	☐ Syncope (<i>fainting</i>)	
Vascular	☐ Claudication (<i>pain in calves / thighs / buttocks while walking</i>)	☐ Edema (<i>legs and ankles swell</i>)	
Constitutional	☐ Weight Gain	☐ Weight Loss	☐ Fever
HEENT	☐ Visual Changes	☐ Hearing Loss	
Respiratory	☐ Snoring	☐ Hemoptysis (<i>bloody sputum</i>)	☐ Dyspnea (<i>shortness of breath with activity</i>)
Gastrointestinal	☐ Nausea	☐ Reflux	☐ Bleeding (<i>rectal bleeding / black or bloody stools</i>)
Genitourinary	☐ Hematuria (<i>blood in urine</i>)	☐ Nocturia (<i>night-time urination</i>)	
Neurological	☐ Dizziness	☐ Memory Loss	☐ Seizures
Psychiatric	☐ Depression		
Hematologic	☐ Acute Anemia		
Reproductive	☐ Erectile Dysfunction		
Endocrine	☐ Goiter (<i>thyroid gland growth</i>)		
Derm	☐ Rash	☐ Skin Sores	
Musculoskeletal	☐ Joint Pain	☐ Myalgia (<i>muscle pain</i>)	