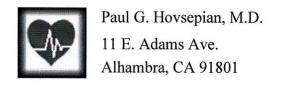


Paul G. Hovsepian, M.D. 11 E. Adams Ave. Alhambra, CA 91801

PATIENT INFORMATION FORM

Date:		
Patient's Name: (last)	(first)	(middle)
Alternate name:(If different from above)		Sex: ☐ Male ☐ Female
Street Address:(Include apt/suite number)		
City:	State:	Zip code:
Telephone (home): ()	Te	elephone (other): ()
Date of birth:	_ Social security #: _	
Primary Care Physician:		
Marital status: ☐ Single ☐ Ma	rried Life Partner Div	vorced □ Widowed □ Separated
Spouse/partner's name:	8 9	Spouse/partner's DOB:
Spouse/Partner's Social security	#:	
Emergency contact informatio	n:	
Name:	Telephone:	Relationship:
Name:	Telephone:	Relationship:
Name:	Telephone:	Relationship:
4		
Insurance information:	the state of the s	
1.Primary Insurance Carrier:	Primary Insurance Carrier	Address: Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Primary Insurance Phone #	Policy and/or Subscriber II	D# Group#
2.Seconday Insurance Carrier:	Secondary Insurance Carrie	Relationship to Policy Holder: □ self □ spouse □ parent
Secondary Insurance Phone #	Policy and/or Subscriber II	D# Group#

3.Tertiary Insurance Carrier: Tertiary Insurance		ce Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent				
Tertiary Insurance Phone # Policy and/or Su		bscriber ID#	Group #				
Work or Auto Injury? ☐ Yes ☐ No		have an attorney Yes No	If yes, list attorney and	d/or W/C adjustor's name and phone #			
BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION I HAVE PROVIDED IS							
TRUE AND CORRECT Signature of Patient o	Date signed:						



How long?

NEW PATIENT HISTORY

Date:					Referring MD:		
Patient:					Reason For Your Visit:		
DOB:/ Age:		_ Sex:	M	F			
Medication Allergies:							
Pharmacy:					Date of Symptom(s) Onset:		_
	** SI	ELECT	YES I	IF YO	U HAVE EVER HAD**		
CAPDIAC PROCEDI	DAI III	ISTOR	v		VASCIII AD DDOCEDVIDAT VI	(CTODY	
CARDIAC PROCEDU	KAL H		e in Mi		VASCULAR PROCEDURAL HI	STORY	
1. Heart Attack If yes, when?			YES	NO	1. Pain in calves/thighs/buttocks while walking?	YES	NO
					How far do you walk prior to pain?		
Coronary Angiogram or balloon/stent procedure? If yes, when?			YES	NO	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
3. Heart Surgery?			YES	NO	5. Carotid Doppler?		
If yes, type: whe	en:				(ultrasound of arteries of neck)	YES	NO
4. Echocardiogram? (ultrasound o	of heart)		YES	NO	6. Arterial Doppler? (leg circulation test)	YES	NO
		*					
	CARL	OIOVA	SCU	LAR	RISK FACTOR SURVEY		
1. Do you smoke/chew tobacco?	YES	NO	3.	Do yo	ou have a history of Peripheral Vascular Disease	? YES	NO
Have you in the past?	YES	NO	4.	Do yo	ou have a history of high blood pressure?	YES	NO
a. Packs/day?				How	long?		
b. Years smoked?			5.	Do yo	ou have a history of high blood cholesterol?	YES	NO
a. Packs/day?			6.	Is the	re a family history of Please list relationship		
2. Are you diabetic?	YES	NO		a. I	Heart Disease?	YES	NO
Type 1 or Type 2?				b. I	Diabetes?	YES	NO

c. Cancer? _____

d. Stroke?

YES NO

PAST MEDICAL HISTORY Previous Surgeries and Chronic Conditions Type <u>Date</u> YES NO History of Stroke? Any lung disease? (COPD, Asthma) YES NO Any GI Issues? (PUD, cirrhosis) YES NO 3. Any blood disorders? (anemia) YES NO YES NO Are you on Dialysis? YES NO 6. History of cancer? 8. 9. 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			
Name and the second	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 (sweating)	☐ Orthopnea (difficulty breathing while laying down)
	□ Palpitation	□ Syncope (fainting)	
Vascular	☐ Claudication (pain in calves / thighs / buttocks while walking)	□ Edema (legs and ankles swell)	
Constitutional	□ Weight Gain	□ Weight Loss	□ Fever
HEENT	□ Visual Changes	□ Hearing Loss	
Respiratory		□ Hemoptysis (bloody sputum)	□ Dyspnea (shortness of breath with activity)
Gastrointestinal	□ Nausea	□ Reflux	□ Bleeding (rectal bleeding / black or bloody stools)
Genitourinary	□ Hematuria (blood in urine)	□ Nocturia (night-time urination)	
Neurological	□ Dizziness	□ Memory Loss	□ Seizures
Psychiatric	□ Depression		
Hematologic	□ Acute Anemia		,
Reproductive	□ Erectile Dysfunction		
Endocrine	□ Goiter (thyroid gland growth)		
Derm	□ Rash	□ Skin Sores	
Musculoskeletal	□ Joint Pain	□ Myalgia (muscle pain)	