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.Seconday 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 #

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: _____
Patient: _____
DOB: ____/____/____ Age: _____ Sex: M F
Medication Allergies: _____
_____
Pharmacy: _____

Referring MD: _____
Reason For Your Visit: _____
_____
_____
_____
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
   Have you in the past? YES NO
   a. Packs/day? _____
   b. Years smoked? _____
   a. Packs/day? _____
2. Are you diabetic? YES NO
   Type 1 or Type 2? _____
   How long? _____
3. Do you have a history of Peripheral Vascular Disease? YES NO
4. Do you have a history of high blood pressure? YES NO
   How long? _____
5. Do you have a history of high blood cholesterol? YES NO
6. Is there a family history of… *Please list relationship*
   a. Heart Disease? _____ YES NO
   b. Diabetes? _____ YES NO
   c. Cancer? _____ YES NO
   d. Stroke? _____ YES NO

PAST MEDICAL HISTORY

Previous Surgeries and Chronic Conditions

	Type	***Date***	
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 Married Divorced Widowed Life Partner Unknown

Children: YES NO

Caffeine Status YES NO

Types (select 2): Coffee Soda Chocolate Tea Tablets

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	□ Snoring	□ 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)*	