CVTSA *Connecticut Vascular & Thoracic Surgical Associates, P.C.*

Patient Registration Form

Account #

BIOGRAPHICAL INFORMATION

Patient Name: Last/First/Middle Initial:	Birth Date:	Age:	Gender: ☐ M ☐ F	Social Security #:
Address/Street:	Home Phone:	Cell Phone:		Email:
City/Zip:	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed			Name of Spouse/Parent:
Occupation: ☐ Retired	Employer:			Emergency Contact & Phone #:
Primary Care Physician:	Cardiologist:			Referring Physician:
Podiatrist:	Reason for Visit:			Pharmacy Name/Location:

INSURANCE INFORMATION

Primary Insurance:	Policy #:	Name of policy holder:	Relation to policy holder:
Secondary Insurance:	Policy #:	Name of policy holder:	Relation to policy holder:

MEDICAL HISTORY

List any personal past/present illnesses:	Previous surgeries:	List all current medications & dosage:

List any known allergies to medication/food/dye:	List all serious illnesses in your immediate family (blood relatives only):
Do you smoke? ☐ Yes ☐ No ☐ Quit When? How long? How much?	Do you drink alcohol? ☐ Yes ☐ No ☐ Used to How long? How much?

SYSTEMS REVIEW (check all that apply to you) Do you now or have you had any problems related to the following systems?

Constitutional (General) ☐ Negative
- ☐ Recent weight loss
- ☐ Fever
- ☐ Chills or sweats
- ☐ History of blood transfusion

Cardiovascular (Heart) ☐ Negative
- ☐ Chest pain or angina or heart attack
- ☐ Palpitations or arrhythmia/irregular heartbeat
- ☐ Leg pain while walking or claudication
- ☐ Varicose veins
- ☐ Leg swelling or edema

Respiratory (Lungs) ☐ Negative
- ☐ Chronic or frequent cough
- ☐ Shortness of breath
- ☐ Congestive heart failure
- ☐ Wheezing or Asthma or COPD
- ☐ Coughed up blood (hemoptysis)

Psychological (Mental) ☐ Negative
- ☐ Anxiety/Nervousness
- ☐ Depression
- ☐ Other:

Head & Neck ☐ Negative
- ☐ Frequent or recurrent sinus infections
- ☐ Visual or speech disturbances
- ☐ Hard of hearing
- ☐ Difficulty swallowing

Gastrointestinal (Stomach) ☐ Negative
- ☐ Abdominal pain or cramps
- ☐ Indigestion or heartburn/reflux or ulcers
- ☐ Nausea or vomiting
- ☐ Diarrhea or constipation
- ☐ Vomited blood
- ☐ Dark black or tarry stools/blood with stools
- ☐ Liver disease

Male Genital ☐ Negative
- ☐ Sexual trouble
- ☐ Enlarged prostate/BPH
- ☐ Prostate cancer

Female Gynecological ☐ Negative
- ☐ # of pregnancies: _____
- ☐ Last menstrual period: _____

Urinary/Renal (Kidneys) ☐ Negative
- ☐ Burning or blood with urination
- ☐ Urgency or frequency of urination
- ☐ Urinating several times at night

Musculoskeletal (Bones) ☐ Negative
- ☐ Joint stiffness/pain/swelling
- ☐ Muscle aches
- ☐ Back pain

Neurologic ☐ Negative
- ☐ Frequent or recurring headaches
- ☐ Dizziness
- ☐ Weakness or paralysis
- ☐ Numbness or tingling/neuropathy
- ☐ Stroke or mini stroke/TIA

Endocrine/Hematologic ☐ Negative
- ☐ Excessive thirst
- ☐ Heat or cold intolerance
- ☐ Bleeding or bruising tendency
- ☐ Enlarged nodes/swollen glands
- ☐ Blood clots/DVT
- ☐ Thyroid problems

AUTHORIZATION:

I authorize release of my medical information to process my insurance and to direct payment of medical benefits to my physician.
If my insurance does not pay, I am responsible for payment of my bill.

Signature: _____ **Date:** _____ **Reviewed by:** _____ **Date:** _____