Laurelton Heart Specialist

Dr. Ola Akinboboye M.D
234-36 Merrick Blvd
Laurelton NY, 11422
Office #: (718)949-9400
Fax: (718)949-8300

Patient Name: _____

Date of Birth: _____ **Soc. Sec #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home # :(_____) _____ **Cell # :(_____)** _____

Marital Status: _____ **Sex: M_____F_____**

Email: _____

Emergency Contact: _____

Phone #: (_____) _____ **Relationship:** _____

Primary Care Dr.: _____ **Phone :(_____)** _____

INSURED INFORMATION
(IF SAME AS ABOVE WRITE SAME)

Insured Name: _____

Date of Birth: _____ **Soc. Sec #:** _____

Relationship with patient: _____

INSURANCE INFORMATION

Insurance Company: _____

Policy#: _____ **Group #:** _____

Insurance Address & Number: _____

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We keep a record of the healthcare services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get information about it by contacting Tiffany Washington

Our **Notice of Privacy Practices** describes in more details how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the **Notice of Privacy Practices.**

_____ _____

Patients or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (Parent, Legal guardian, Ex)

This form will be retained in your medical records.

Last Update : ____/_____/_____

Laurelton Heart Specialist
234-36 Merrick Blvd

PATIENT FINANCIAL LIABILITY STATEMENT

I understand that I am personally financially responsible for charges incurred for services rendered by Laurelton Heart Specialist if any of the following apply:

1. My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at **Laurelton Heart Specialist** and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral. and/or
2. My health plan determines that the services I received at **Laurelton Heart Specialist** are not medically necessary. and/or
3. My health plan coverage has lapsed or expired at the time I receive services at **Laurelton Heart specialist**. And/or
4. I have chosen not to use my health plan coverage.

I also understand that I am responsible for all co-payments and co-insurance sums and deductibles under my health plan.

_____ _____
Print Patient Name Patient Medical Records No.

_____ _____
Print guarantor's name if not the Patient Date

_____ _____
Signature of Financially responsible Party Registrar Initials

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Please list all the medications that you are currently taking.

Today's Date: _____

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

BALANCE

Balance Self Test

Are You At Risk For Falls?

Patient Name: _____ SSN: _____

1. Have you fallen more than once in the past year?	YES	NO
2. Do you lose balance when standing still, or when you initially get up after sitting?	YES	NO
3. Does it take you more than one try to get out of a chair or out of bed?	YES	NO
4. Do you lose your balance or feel unsteady when walking?	YES	NO
5. Do you get dizzy, faint or have seizures?	YES	NO
6. Do you take unnecessary risks (i.e. standing on chairs or walking on slippery floors?	YES	NO
7. Do you trip over your own feet or objects on the floor?	YES	NO
8. Do you take corners too sharp and bump into corners or door frames?	YES	NO
9. Do you use a walker, cane or need assistance to get around?	YES	NO
10. Have you had a recent loss or decrease in, vision or hearing?	YES	NO
11. Do you have numbness or loss of sensation in your feet or your legs?	YES	NO
12. Have you experienced a stroke or any other health problems that may have affected your balance?	YES	NO

If you answered YES to one or more questions, you may have a balance problem. If you are concerned about falling, or simply want to take a balance test please speak to your physician.

Cardiopulmonary Survey

Your heart may be telling you something!

1. Do you get short of breath with minimal exertion? Yes No
2. Do you avoid certain physical activities you did in the past? Yes No
3. Do you ever get chest pain? Yes No
4. Do you tire or fatigue easily? Yes No
5. Does your heart ever race or skip beats? Yes No
6. Do you have family members with heart disease? Yes No
7. Do you have diabetes? Yes No
8. Do you have high blood pressure? Yes No
9. Do you have high cholesterol? Yes No
10. Do you smoke or have a history of smoking? Yes No
11. Have you ever lived with a smoker? Yes No
12. Do you have trouble breathing when you lie down? Yes No
13. Do you snore? Does your spouse note you stop breathing when sleeping? Yes No
14. Do you have swelling in your legs or feet? Yes No
15. Do you have sudden movements in your legs at night Yes No

Health Sleep Disorder Check-Up

Your physician is requesting that you complete this survey prior to your visit today. Once completed, please give it to the medical assistant when you are called to be taken to the exam room. If you have recently completed this survey please let the medical assistant know.

The survey is used to determine the need for you to have a sleep test. This test is to evaluate if you have a sleep disorder which is negatively affecting your cardiovascular health and well being.

First Name: _____ **Last Name:** _____

E-Mail Address_____ **Physician Name:** _____

Part 1.

1. Have you ever been told you have Congestive Heart Failure? Yes ___ No ___
2. Have you ever been told you have Coronary Artery Disease? Yes ___ No ___
3. Have you ever had a stroke? Yes ___ No ___
4. Do you take 3 or more medications for high blood pressure? Yes ___ No ___
5. Have you ever experienced irregular heart rhythms (atrial fibrillation) Yes ___ No ___
6. Have you ever been told that you stop breathing at night? Yes ___ No ___

Part 2

1. Have you been told that you snore loudly? Yes ___ No ___
2. Do you have difficulty breathing at night? Yes ___ No ___
3. Do you awaken from sleep with chest pain or shortness of breath? Yes ___ No ___
4. Does your family have a history of premature death in sleep? Yes ___ No ___
6. Is your neck size larger than 15.5 (female) or 17.0 (male) Yes ___ No ___

Part 3

1. Have you ever been diagnosed with Obstructive Sleep Apnea? Yes ___ No ___
2. Are you currently being treated for sleep apnea? Yes ___ No ___
   2a. If yes, are you using it every night? Yes ___ No ___

Part 4 _____

Chance of dozing using Epworth Sleepiness Scale (0 = never, 1 = slight, 2 = moderate, 3 = high)

1. Being a passenger in a motor vehicle for an hour or more _____
2. Sitting and talking to someone..... _____
3. Sitting and reading..... _____
4. Watching TV..... _____
5. Sitting inactive in a public place..... _____
6. Lying down to rest in the afternoon..... _____
7. Sitting quietly after lunch without alcohol..... _____
8. In a car, while stopped for a few minutes in traffic... _____

Total score _____

Scoring Methodology

One "Yes" in *Part 1* and one "Yes" in *Part 2* or *Part 3* order sleep test or
If total score in *Part 4* is greater than 8, order sleep test.

Provider Use Only:

- ☐ Reviewed, order sleep study, and titration and treatment if positive for OSA.
- ☐ Reviewed patient's airway
- ☐ Reviewed do not order sleep study.

Physician Signature: _____ Date: _____

REVIEW OF SYSTEMS - Page 2

PATIENT NAME: _____ DATE: _____

		YES	NO	IF YES - Describe in detail
Skin:	Change in Color			
	Pallor (Pale Skin)			
	Wounds/Ulcers			
	New Lesions			
	Other			
Gastrointestinal:	Nausea			
	Vomiting			
	Diarrhea			
	Constipation			
	Blood in Stool			
	Other			
Constitutional:	Weight Changes			
	Fever			
Endocrine:	Neck Swelling			
	Palpitations			
	Sweats			
	Other			
Immunologic:	Frequent Infections			
	Other			

ertinent Cardiovascular only
Extended: 2-9 systems
Complete >10 systems

eviewed by Provider: _____ _____ _____
NAME SIGNATURE DATE

HISTORY & PHYSICAL

NAME:	DATE OF BIRTH:	TODAYS DATE:
ADDRESS:	CITY:	STATE: ZIP:
HOME PHONE: ( )	WORK PHONE: ( )	CELL PHONE: ( )
OC 'ATION/EMPLOYER:	SOCIAL SECURITY #:	REFERRED BY:

REASON FOR REFERRAL:

MEDICATIONS (DOSAGE/Frequency)	5.
1.	6.
2.	7.
3.	8.
4.	Allergies:

HOSPITALIZATIONS: (Year/Reason)

PRIOR CARDIAC HISTORY/TESTS		ARRHYTHMIA		CARDIAC CATHERIZATION	
CHEST PAIN		DIZZINESS/LIGHTHEADEDNESS		ECHOCARDIOGRAM	
HE ATTACK		PALPITATIONS		STRESS TEST	
HIGH BLOOD PRESSURE		FAINTING		HOLTER MONITOR	
VALVE DISEASE		CONGESTIVE HEART FAILURE		PACEMAKER / ICD	

FAMILY HISTORY:ALIVE/DECEASED – REASON, HISTORY	SIBLINGS:
MOTHER:	OTHER RELATIVE:
FATHER:	FAMILY HISTORY OF SUDDEN CARDIAC DEATH:

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

STROKE/TIA	SEIZURES	MIGRAINE	PARKINSONS	NEUROLOGICAL Disorder
HEARING LOSS	VISUAL DISTURBANCE	VERTIGO	NOSE BLEEDS	SINUS
SHORT OF BREATH	ASTHMA	EMPHYSEMA	BRONCHITIS	PNEUMONIA
ULCERS	HEPATITUS/JUANDICE	CROHNS/COLITIS	ESOPHAGEAL DISORDER	HEMATURIA
PHLEBITIS	VARICOSE VEINS	CLAUDICATION	POOR CIRCULATION	SKIN DISEASE
CANCER	ANEMIA	BLEEDING Disorder	BLOOD TRANSFUSION	OTHER
DIABETES	THYROID Disorder	GOUT	ARTHRITIS	OSTEOPOROSIS
MENTAL ILLNESS	DEPRESSION	ANOREXIA	SLEEP Disorder	PANIC Disorder
H IATIC FEVER	TUBERCULOSIS	PREGNANCY	GYN. Disorder	PROSTATE Disorder

MOKING:PK/DAY, # YRS	ALCOHOL: OZ/DAY	COFFEE: #CUPS/DAY

EVIEWED BY PROVIDER:

AME:	SIGNATURE	DATE

REVIEW OF SYSTEMS – Page 1

PATIENT NAME: _____ DATE: _____

Please indicate your previous medical history by answering "yes" or "no" to the following questions:

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

		YES	NO	If YES - Describe in detail
HEENT:	Yellow Eyes/Visual Changes			
	Hair Loss			
	Change in Voice			
	Masses in Head, Eyes, Ears, Nose , Throat			
	Swelling in Neck			
	Other			
Genitourinary:	Hesitation with Urination			
	Burning with Urination			
	Blood in Urine			
	Change in color of Urine			
	Other			
Hematologic/Lymph:	Swelling of Glands			
	Fatigue			
	Blood Clots			
	Prolonged Bleeding			
	Other			
Musculoskeletal:	Weakness			
	Atrophy of Muscles			
	Gait Problems			
	Other			
Neurological:	Weakness			
	Change in Memory			
	Change in Sleep			
	Change in Vision			
	Other			
Psychiatric:	Change in Affect (mood)			
	Other			
Respiratory:	Shortness of Breath			
	Cough			
	Blood in Sputum			
	Other			

Reviewed by Provider: _____ _____ _____

DATE SIGNATURE DATE

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____

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