Please scan and email (or fax) the following pages to us
as soon as you can – well in advance of your visit!!
Email to Cardiac@LevinsonHarris.com Fax to 617 247 9444

Your Full Name
Marital status Married Sngl Sep Div Widow
You live ☐ Alone ☐ With:

Today's Date
Birth Date
MGH Unit #

Your contact info

Address
Phone ( ) --
Cell ( ) --
Fax ( ) --
Email

Spouse or significant other

Name
Phone ( ) --
Cell ( ) --
Email

Work (if retired, what did you do before?)

Company
Job & title
Phone
Retired? Yes / No when:

Emergency contact (not spouse)

Name
Relation
Phone ( ) --
Cell ( ) --
Email

Your primary physician

Name
Address
Phone ( ) --
Fax ( ) --

Other physicians involved in your care

	Name	Specialty	Phone
1			
2			
3			
4			
5			

Your pharmacy name
Location and Phone

Insurance Data	Name of insured	Insurance company	Policy Number
Primary insurance			
Secondary insurance			

Who referred you to us?

What is the main problem leading to this consultation?

Your personal medical history

Yes	No	???	
			Have you **ever** smoked cigarettes?
			High blood pressure
			Diabetes
			High or "bad" cholesterol
			Arterial disease / vascular surgery
			Varicose veins / vein stripping
			Rheumatic Fever
			Heart attack
			Use of Redux or Fen-Phen **ever**
			Heart Surgery / angioplasty

packs/day	# years smoked	Date Quit
		/ /

Please write any comments below

			Dentures / partial plates
			Other Surgery
			Anything else? Write it in please

Disease which **run in your family** (your: parents, grandparents, siblings, aunts/uncles, children)

Yes	No	???	
			Heart attack/angina
			Atrial fibrillation
			Cardiomyopathy
			Sudden death
			Mitral prolapse
			Hypertension (high blood pressure)
			High cholesterol
			Aortic aneurysm
			Brain aneurysm
			Stroke
			Diabetes
			Breast cancer
			Colon or rectal cancer
			Ovarian or uterine cancer
			Prostate cancer
			Other cancers???

Medications you are **currently** taking

	Name of the medication	# mg in each tablet	# of pills taken at a time	# of times you take this in a day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Medication Allergies and intolerances

Allergy to X-Ray contrast dye? YES NO Never had it

Habits, activity, & misc

Alcohol - drinks per day	None Rare 1/day 2/day 3 or
Recreational Drug use	Neve other
Caffeine, cups per day	None Rare 1/day 2/day 3 or
Salt	No added salt low unrestricted
Fat	Very low low unrestricted
What exercise do you do	None Walking Cardio Resistance Other:
How many days per week	None 1 2 3 4 5 6 7
Weight <u>now</u>	
Weight <u>at 20yo</u>	
Height	
Waist & collar sizes	

Immunization history – Please write month and year for most recent immunizations

	MM/YY		MM/YY
Hepatitis A		Pneumovax (pneumonia)	
Hepatitis B		Flu shot	
Tetanus		Zoster (shingles)	

Your health maintenance history

	Most recent MM/YY	Where was it done?	Results?
Colonoscopy			
Mammogram			
Gynecology exam			
Bone density scan			
Abdom Aorta ultrasound			
Carotid ultrasound			

Please check any CURRENT SYMPTOMS you are having

❑ Fevers, chills, sweats	❑ Fainting	❑ Muscle or joint pains
❑ Weight loss	❑ Breast lump	❑ Rash
❑ Weight gain	❑ Nipple discharge	❑ Changing moles
❑ Excess thirst	❑ Cough	❑ Itching
❑ Excess hunger	❑ Wheezing	❑ Headache
❑ Change in vision	❑ Short of breath	❑ Dizzy
❑ Hearing loss	❑ Abdominal pain	❑ Memory loss
❑ Ringing in ears	❑ Blood in bowel movement	❑ Confusion
❑ Oral/dental trouble	❑ Nausea/vomiting	❑ Muscle weakness
❑ Hay fever	❑ Diarrhea/constipation	❑ Loss of coordination
❑ Allergies	❑ Other change in stool	❑ Anxiety / stress
❑ Chest pain	❑ Vaginal bleeding	❑ Depression
❑ Leg ache with exertion	❑ Leaking urine	❑ Trouble with sleep
❑ Palpitations	❑ Penile/vaginal discharge	❑ Easy bruising
❑ Lightheadedness	❑ Sexual problems	❑ Unexplained lumps

Please write any other comments below

Your Communication Preferences

Your preferred contact phone (circle top choice)	Cell	Home	Work
May we leave detailed messages at preferred phone?	Yes	No	
May we use unencrypted email to reach you?	Yes	No	
May we speak freely with spouse or significant other from previous page?	Yes	No	
May we speak freely with emergency contact from previous page?	Yes	No	
May we fax protected medical information to your fax number above?	Yes	No	

Please use the following lines to enter any other information to help in our communications. For example, you might enter other phone numbers for you; names and numbers for children or parents, your assistants, and so on. For each, please indicate the relationship and the kinds of things for which we should reach out to them. Please also indicate any more general communication preferences, if any pertain.

AllCare Medical, LLC – E-mail Communications

The undersigned patient (Patient) wishes or declines to communicate with AllCare Physician, Affiliated Physicians, their Associates, and/or Allcare (AllCare) by unencrypted e-mail regarding matters which may include the Patient's Protected Healthcare Information (PHI) and hereby agrees to the following provisions.

Patient acknowledges that:

- **E-mail is not a secure medium for sending or receiving PHI and, in particular, if Patient uses an employer's e-mail system, the employer has the right to review any such communications;**
- **Although Allcare will make reasonable efforts to keep e-mail communications among the Patient, and AllCare (and the employees, agents and representatives of AllCare) confidential and secure, AllCare cannot assure or guaranty the confidentiality of e-mail communications,**
- **In the discretion of patient's AllCare physician, e-mail communications may be made a part of Patient's permanent medical record; and**
- **E-mail is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information.**

Patient agrees that:

- **Patient will not use e-mail for communication regarding emergencies or other time-sensitive issues, or for communication regarding other sensitive information, but rather will communicate such information as necessary through other means, such as telephone or in person.**
- **If Patient does not receive a response to any e-mail message within one (1) day (or such longer time as Patient indicates in the e-mail), Patient will use another means of communication to contact AllCare,**
- **Patient will include his/her full name and a short description of the subject matter of the e-mail (e.g., "prescription refill", "medical advice", "billing question") in the Subject line of the e-mail;**
- **When responding to e-mails from each other, AllCare and Patient or their representatives will "Reply with History" to ensure that the recipient is aware of previous communication,**
- **Allcare shall not be liable to Patient for any loss, cost, injury or expense caused by, or resulting from: (i) a delay in response to Patient due to technical failures, including, but not limited to, technical failures attributable to Allcare's internet service provider, power outages, failure of Allcare's electronic messaging software, failure by Allcare or Patient to properly address e-mail messages, failure of Allcare's computers or computer network, or faulty telephone or cable data transmission; (ii) any interception of e-mail communications by a third party; or (iii) Patient's failure to comply with the guidelines regarding use of e-mail communications set forth in this agreement.**

_____ _____

Patient's Printed Name Date

Patient AGREES to use email for PHI with provisions above	Patient DECLINES to use email
_____ Signature	_____ Signature
_____ Primary email address to be used	
_____ Other approved email address	

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Massachusetts General Hospital and Massachusetts General Physician Organization are members of Partners Healthcare and Partners Community Healthcare, an integrated health care system which includes all the entity is listed on the back of the Privacy Notice. These hospitals and entities, as well as the doctors, nurses, therapists, and other providers of healthcare who work in these organizations are cold providers for the purpose of this document. These providers may share patient health information for treatment, billing, and healthcare operations.

Federal law requires that all patients be given a copy of the Massachusetts General Hospital Privacy Notice. The Privacy Notice describes in detail how patient health information is used and shared with others.

Massachusetts General Hospital has reserved the right to change the Privacy Notice at any time. You may obtain a current copy of the Privacy Notice by contacting the admitting office, the registration office, your physician's office or by going to the MGH website: Http://www.MassGeneral.org/privacynotice.htm.

I hereby acknowledge that I have been given a copy of the Massachusetts General Hospital Privacy Notice

_____ / _____ / _____

signature printed name Date

MEDICAL RECORDS/X-RAY RELEASE AUTHORIZATION

To the patient: Please copy this form and execute a signed original for *every* physician and hospital having medical records relevant to your cardiovascular problems.

To:
Doctor / Hospital: _____

Address _____

_____

I hereby authorize and request you to release to Dr. Levinson's office at the address above, the following medical information.

- ☐ Complete medical records
- ☐ Cardiac cath reports
- ☐ Cardiac cath films/CDROMs
- ☐ Cardiac surgery reports
- ☐ Other cardiac data (stress, Holter, echo, etc.)
- ☐ Pacemaker data
- ☐ Hospital discharge summaries
- ☐ All of the above

Desired timeframe:

- ☐ All dates available

Or ☐ Dates of interest: _____ until _____

Patient name (please print) _____

SS #_____ date of birth _____

Address _____

_____

_____

X_____ _____

Signature Date

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health issues, or drug and alcohol use. If I have been tested, diagnosed or treated for any of the aforementioned issues you are specifically authorized to release all information relating to set issues.

X_____ _____

Signature Date