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Dear Patient:

Welcome to St. Luke's Clinic - Cardiothoracic & Vascular Associates. You have been scheduled for an appointment with one of our physicians in our office downtown at 333 N. 1st St. #280, Boise, ID 83702.

In an effort to expedite the time you will spend in our office, we are enclosing forms for your completion prior to your scheduled appointment. Please take the time to complete the forms at your convenience, and bring the completed forms to your office appointment.

The following items will be needed for your initial appointment:

1. Patient Information and Consent Sheet.
2. Patient Health History Exam Form (*fully completed*). If there is not enough room on the form, please attach a separate list of medications (include dosage amount and frequency), surgical history and/or allergies.
3. All insurance cards (*primary and all secondary coverages*)
4. Picture identification card

If you have other questions about the forms or about your scheduled appointment, please call (208) 345-6545. If you are unable to keep your scheduled appointment, please call to cancel or reschedule.

Thank you.

The Staff at St. Luke's CVA

**ST. LUKE'S CLINIC - CARDIOTHORACIC & VASCULAR ASSOCIATES
PATIENT INFORMATION AND CONSENT**

Date _____ Doctor _____ Account # _____

Last Name _____

Sex _____ (M)ale (F)emale

First Name _____

Marital Status: Single Married Divorced

Address _____

Separated Widow Minor

Employer _____

City _____ State _____ Zip _____

Family Physician _____

Home Phone () _____

Referring Physician _____

Work Phone () _____

Other Physician to Contact _____

Cell Phone () _____

Emergency Contact _____

E-mail _____

Relationship _____ Phone _____

Date of Birth _____

If married, Spouse's Name _____

Social Security # _____

Spouse's DOB _____ SS# _____

Age _____

How did you hear about us? _____

BILLING INFORMATION

Do you have medical insurance? Yes No

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

Name _____

Name _____

Address _____

Address _____

ID # _____

ID # _____

Group # _____

Group # _____

Subscriber _____

Subscriber _____

Birth Date _____

Birth Date _____

Social Security # _____

Social Security # _____

Responsible Party _____

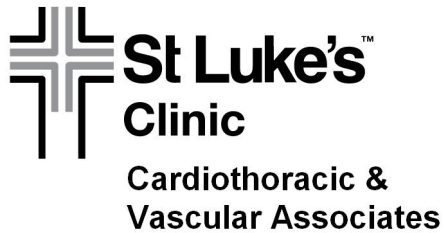
Phone _____

As patient or legal guardian of patient, I agree to be fully responsible for all charges for services rendered. I authorize my doctor or his agent to submit claims to Medicare or my insurance carriers for charges incurred. I authorize my Medicare or insurance benefits to be paid directly to the doctor. I understand that there is a possibility of non-coverage by my insurance companies or Medicare. If they determine that any service is deemed "medically unnecessary", I agree to assume responsibility for denied payment. I further authorize this office to obtain and release my medical records to and from other physicians, medical facilities, insurance companies and Medicare to facilitate my health care and appropriate payments.

Do you authorize release of your medical information to anyone besides your insurance carrier? Yes No If so, whom? _____

Signature _____

Date Signed _____



Welcome to our Practice
MEDICAL HISTORY FORM

Name: _____ **Date:** _____ **DOB:** _____

Chief Complaint: (Main reason for visit) _____

Allergies: If none, please check this box

Drug	Reaction	Drug	Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Have you been told you are allergic to latex? Yes No

Medications: (What medicine are you currently taking?)

Name of Drug	Dosage	Frequency	Name of Drug	Dosage	Frequency
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

Circle if taking: Aspirin Plavix Coumadin Herbal

Past Medical History: (Please check any you have now or have had in the past)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> History of Blood Clots | <input type="checkbox"/> Stroke |

Additional Illnesses:

1. _____ 3. _____
2. _____ 4. _____

Past Surgical History: (What operations have you had?)

Operation	Year	Operation	Year
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Family History: (Do any diseases or medical problems run in your family; i.e. high blood pressure, heart disease, stroke, diabetes, blood clots, cancer, anesthetic problems, etc?)

Problems/Disease	Family member affected	Problems/Disease	Family member affected
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Continue on other side

Social History:

Have you ever smoked? Yes No Quit? Yes No When? _____
If you have smoked, how many packs per day? _____ For how many years _____

Do you drink alcohol? Yes No
How many beers in a week? _____ Glasses of wine per week? _____ Mixed drinks per week? _____

Recreational Drug Use? Yes No

Current Employment: _____

If retired, what kind of work did you do? _____

Review of Systems: (Please check all that apply)

General

- Night sweats
- Chills
- Recent weight change
- Appetite loss
- Fevers
- Fatigue

Eyes

- Glaucoma
- Vision loss - one eye
- Vision loss - both eyes

Ears/Nose/Mouth/Throat

- Hearing loss
- Hoarseness
- Difficulty swallowing
- Nosebleeds
- Sores in mouth

Endocrine

- Excessive thirst or urination
- Heat or cold intolerance
- Thyroid problem

Neurologic

- Frequent or recurring headaches
- Lightheaded or dizzy
- Convulsions or seizures
- Numbness or weakness
- Loss of coordination
- Poor balance
- Inability to speak
- Fainting
- Sudden vision loss

Respiratory

- Chronic cough
- Spitting up blood
- Shortness of breath at rest
- Wheezing
- Excessive snoring
- History of tuberculosis

Cardiovascular

- Heart murmur
- Chest Pain or Discomfort
- Palpitations
- Shortness of breath when walking or lying flat
- Swelling of feet, ankles or hands
- Leg cramps with exertion
- Difficulty breathing
- Racing/skipping heart beats
- Abnormal cholesterol level

Gastrointestinal

- Indigestion
- Change in bowel habits
- Nausea and/or vomiting
- Diarrhea
- History of Jaundice
- Heartburn
- Rectal bleeding
- Blood in stool
- Dark tarry stools
- Ulcers
- Constipation
- Yellow skin color
- Vomited blood
- Abdominal pain

Musculoskeletal

- Muscle pain or cramps
- Gout
- Arthritis
- Joint swelling

Psychiatric

- Anxiety
- Depression
- Memory loss or confusion

Blood/Lymphatic

- Bleeding tendency
- Enlarged lymph nodes

Allergic/Immunologic

- HIV exposure
- Hives or rash
- Seasonal allergies

Genitourinary

- Frequent Urination
- Blood in urine
- History of kidney stones
- Erectile dysfunction
- Inability to empty bladder
- Painful urination
- Night time urination
- Inability to empty bladder
- Trouble starting urinary stream

Skin

- Poor wound healing
- Changing moles
- Skin cancer

Do you feel safe in your home environment Yes No

What is your preference for learning? (circle one) Verbal Visual Auditory Demonstration

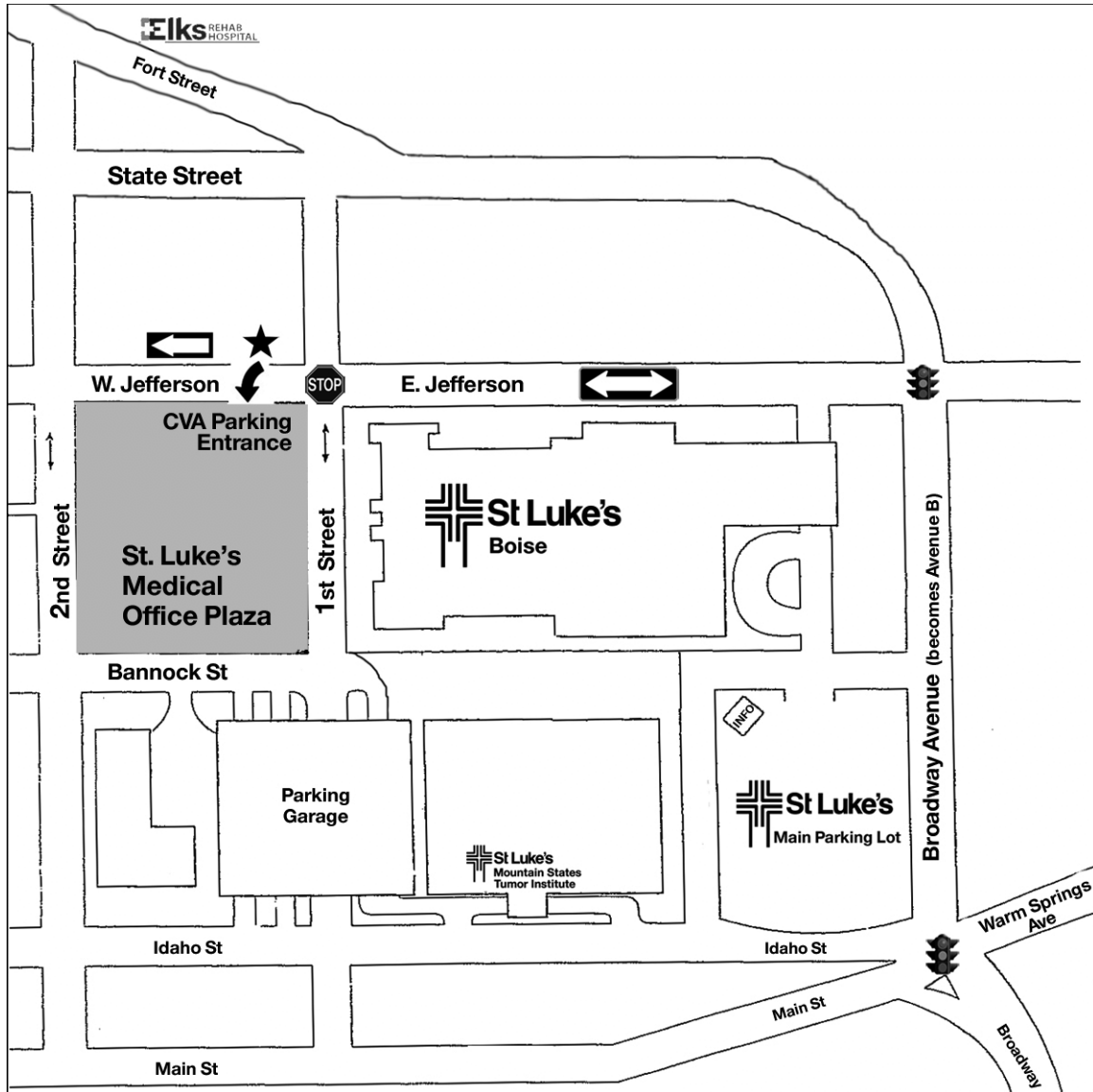
What is your language preference? (circle one) English Spanish Other _____



St Luke's™
**Cardiothoracic &
Vascular Associates**

333 N. 1st Street, Suite 280
Boise, ID 83702
208-345-6545

We are located in the **St. Luke's Medical Office Plaza** at the corner of 1st and Jefferson St in downtown Boise just west of St. Luke's Boise Medical Center. Free parking is available within the parking garage of our building - Enter off of Jefferson St.



Directions:

From the West, take City Center exit (I-184) to Broadway and turn left. Continue on Broadway to Jefferson and turn left. Cross 1st Street and enter the SLMOP parking garage on the left side of Jefferson.

You may drive to the second level for the closet parking to our office.

From the East, take Broadway exit. Go north on Broadway to Jefferson Street and turn left. Cross 1st Street and enter the SLMOP parking garage on the left side of Jefferson.

You may drive to the second level for the closet parking to our office.