HEARTWISE

A wholehearted approach to living.™

Your appointment is scheduled for / /

at: am pm

Cancellation Policy:

Please inform us at least 72 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients. Please note that we reserve two hours of time with our staff for your appointment, so late cancellations significantly affect us.

Patients who cancel or reschedule less than 72 hours prior to their appointment will be charged a $200 cancellation fee.

Please contact our office with any questions at Ph. 512-462-3627

Victory Medical Center
4303 Victory Drive
Austin, TX 78704

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Appointment Preparation Instructions

1. Fasting

- Feel free to drink water and up to one (1) cup of coffee prior to your visit. However, please avoid carbonated beverages or beverages with sugar in them, including juice, for eight (8) hours leading up to your visit.
- Please refrain from eating for eight (8) hours prior to your visit
- Take medications as you normally would with water
- You are welcome to bring a snack to eat after the fasting portions of your tests have been completed. We will also have snacks, drinks, and coffee on hand for you.

2. Shoes

- Please bring footwear that is appropriate for a slow 3 minute walk on a treadmill

3. Medical History

- Please fill out the attached Patient Medical History forms as much as possible prior to your appointment. While we recognize that everyone has filled out medical history paperwork before, we still encourage you to fill this out! We do review everything in detail and we use all of the information you provide.

  This may be one of the most comprehensive evaluations you have ever received, and having this snapshot of your health and medical history can be extremely useful for you at later times in your life, as well as to your children and grandchildren for their own health.

Your provider may omit specific tests depending on their medical appropriateness for you; however, if you prefer that they be conducted, please discuss this with your provider.

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Medical History Reviewed By:

____
Medical Provider Signature

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Patient Packet

Please complete this form and bring it with you to your appointment.
If you are unable to answer any questions, please let our staff know, and they will help you complete it.

A detailed family medical history can help our medical providers interpret the history of disease in your family and identify patterns that may be relevant to your own health. This form will help assess your risk of certain diseases, determine which diagnostic test to order as well as type and frequency of screening tests, identify a condition that might not otherwise be considered, and assess your risk of passing a condition on to your children.

Legal Name: ______________________________ *Note: Write name as it appears on Government issued ID*

Date of Birth: ____/____/____ Gender (circle one): Male Female

Address: ______________________ City: ______________ State: ____ Zip: ________

Primary Phone (cell): ( ) ____-______ Alternate Phone: ( ) ____-______

Email address: ______________________________

**All contact information is kept confidential and is not shared*

Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Widow/Widower ☐ ________

Living Situation: ☐ Alone ☐ Significant Other ☐ Relative ☐ Children ☐ ________

Heritage: ☐ African American, Hispanic or Indian Sub-continent (India, Pakistan, Sri Lanka, etc.) ☐ Caucasian ☐ Asian

Occupation/Company you work for: ______________________ Title: ______________

DIAGNOSTIC TEST(S), PROCEDURES, SURGERY HISTORY

List any past health-related testing, diagnostic tests, hospital visits, procedures or surgeries.

Do not write "My physician has copies of all tests"

Type	Current Problem	Past Problem	Date of Test/Procedure/Surgery	Physician or Hospital
Example: Cath Procedure		X	May 11, 1999	Dr. Smith
E.g. Allergy Testing / DNA Testing	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Comments/Notes:

____

____

DIAGNOSIS / MEDICAL PROBLEMS IDENTIFIED

List all medical problems you have ever had at any time, including current problems. Include all diseases or illnesses you have been told you have or for which you have received treatment or taken medications or supplements for.

Condition:	Current Problem	Past Problem	Date when first diagnosed:	Date resolved or discontinued medication:
Example: Psoriasis	X		June 14, 1996	Currently on Enbrel
E.g. Allergies	☐	☐		
E.g. Pain	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

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PERSONAL MEDICAL HISTORY

Check ALL that apply and circle the issues that trouble you the most.

	Yes	No	Explain/Clarify
High cholesterol			
High blood pressure			
Elevated Sugar Levels or Diabetes			
Problems sleeping			

MEDICATIONS AND SUPPLEMENTS

List **all** prescription and over-the-counter medications/supplements you're currently taking or have ever taken. Include oral, inhaled, and injected medications/supplements, as well as drops, sprays, suppositories, creams and ointments.

Medication/Supplements:	Dosage/Frequency:	Reason for taking:	Date started:
Example: Suboxone	50 mg once per day	Drug withdrawal	March 2015

FAMILY HISTORY

Please provide as much detail as you are able: Adopted: ☐ Yes ☐ No

We understand you may not have all information!

Indicate approximate age when diagnosis was first made:	Mom	Dad	Sister	Brother	Daughter	Son	Grandparents MGF/MGM PGF/PGM	Comments:
Example: Stroke	42		30				MGM-62	
High blood pressure								
High cholesterol								
Diabetes (I & II)								
Cancer								
Heart attack								
Heart failure								
Heart surgery/stent								
Angina (heart pain)								
Leg circulation problem								
Failing kidneys								
Stroke								
Smoking								
Dementia/Alzheimer's								
Alcoholism								
Arthritis								
Birth defects								
Hearing problems								
Sudden death								
Genetic disease								

Note: MGF=Maternal Grandfather, MGM=Maternal Grandmother, PGF=Paternal Grandfather, PGM=Paternal Grandmother

Please include any other details related to your family history: ______________________________

____

____

Phase of Life (Women only)

Date of Last Menstrual Period: ____________________ Menopause at age: __________

☐ I am pre-menopausal ☐ Experiencing menopause ☐ Other/NA: ____________________

Please indicate any specific health concerns you would like to discuss with your provider or any information you would like to receive:

How did you hear about us?

☐ Heard of center from
☐ Physician referral
☐ Radio
☐ Print advertisement
☐ Mailing
☐ My Medical Provider
☐ Internet
☐ Word of mouth:
☐ Other

Specify: ____________________

Would you like us to send your results to another health care provider? ☐ Yes ☐ No

If yes, we will need his or her first and last name, complete address and your signature as authorization.
*Please note, if the name and address are not filled out completely, results will not be sent.

Providers Name: ____________________

Clinic Name: ____________________

Street Address ____________________

City, State, Zip ____________________

Phone ( ) ____________________

Patient Signature: ____________________

Internal Purposes Only
History reviewed by (Provider Signature): ____________________

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