Signet Heart Group
2800 North U.S. Hwy 75
Sherman, TX 75090
Patient Health Questionnaire

NAME: _____ **DATE**: _____

Please answer the following questions to the best of your ability. This will help your doctor know more about you. These answers, of course, are confidential.

Are you retired? ☐ Yes ☐ No

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

If currently employed, what type of work do you do? _____

Do you smoke? ☐ Yes ☐ No, but used to ☐ Never

If you used to smoke, when did you quit? _____

How many packs of cigarettes do you or did you smoke and for how many years?

(Example: 1 pack/day for 20 years) _____

Do you drink alcohol? ☐ Yes ☐ No, but used to ☐ Never

If you used to drink, when did you quit? _____

How much do you or did you drink in an average week?

☐ 0-1 drinks or beers/week, ☐ 1-5, ☐ 6-10, ☐ more than 10

Do you have a history of Drug Use/Abuse? ☐ Yes ☐ No

Are you following any special diet? ☐ Yes ☐ No If yes, please specify:

_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list please:_____

Are you allergic to iodine, shrimp, or shellfish? ☐ Yes ☐ No

Have you ever received x-ray contrast in your vein for any reason (myelogram, kidney series, CAT scan, etc.)?

☐ Yes ☐ No If yes, did you have a problem with this? _____

Have you had recent imaging done in the last 6-12 months? If so, Where? _____

☐ Heart ☐ Chest ☐ Head ☐ Legs ☐ Abdominal ☐ Other:_____

Have you had a blood transfusion? ☐ Yes ☐ No If so, When? _____

Have you had any recent hospitalizations in the last year? If so, When and Where? _____

Have you had any operations or surgeries in the past? ☐ Yes ☐ No

If yes, what type and approximate date _____

_____

Please list all medications (prescription and non-prescription) you are supposed to be taking at home (see example).

	NAME	DOSE/STRENGTH	NUMBER TAKEN AT TIME OF DAY
EXAMPLE:	**Lasix**	**40mg.**	**2 at 9 a.m., 1 at 6:00 p.m.**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____

Family medical history:

Father's age _____, or age at death _____ cause of death _____.

Mother's age _____, or age at death _____ cause of death _____.

Sibling, (brother or sister), age, or age at death:

1) _____, _____ age, _____ age at death
2) _____, _____ age, _____ age at death
3) _____, _____ age, _____ age at death
4) _____, _____ age, _____ age at death
5) _____, _____ age, _____ age at death

Medical Problems	**Father**	**Mother**	**Sibling (s)**
1) Heart attack	_____	_____	_____
2) Stroke	_____	_____	_____
3) Diabetes	_____	_____	_____
4) High blood pressure	_____	_____	_____
5) Angina	_____	_____	_____

Other family members with heart problems:
(Example: Paternal uncle, age 55, has a pacemaker.)

_____

_____

_____

_____

_____

_____

Please answer the following questions that relate to health problems that <u>you</u> currently have or have had in the past. Please use a check mark under the "YES" or "NO" column.

	YES	NO
Headaches		
Fatigue or Weakness		
Weight Change -Weight Loss or Weight Gain **(Circle One)**		
Vision Changes-Blurred Vision / Double Vision / Vision Loss **(Circle all that apply)**		
Chest Pain		
Shortness of Breath		
Palpitations / Arrythmias		
Syncope / Passing out Episodes		
Swelling in Legs / Edema		
Varicose Veins		
Coughing		
Wheezing		
Asthma		
Emphysema or COPD **(Circle all that apply)**		
Nausea or Vomiting **(Circle One)**		
Diarrhea or Constipation **(Circle One)**		
Abdominal Pain		
Gallstones		
Reflux		
Back Pain / Joint Pain / Muscle Weakness **(Circle all that apply)**		
Arthritis		
Numbness /Parasthesia **(Circle One)**		
Seizures / Tremors **(Circle One)**		
Dizziness / Vertigo **(Circle One)**		
Rheumatic Fever or Scarlet Fever **(Circle One)**		
Stress / Anxiety / Depression **(Circle all that apply)**		
Memory Loss		
Diabetes		
Thyroid Conditions-Hyperthyroidism or Hypothyroidism **(Circle One)**		
Hypertension-High Blood Pressure		
Cholesterol Problems		
Abnormal Bruising or Bleeding **(Circle all that apply)**		
Tuberculosis		

Please note any other health problems you have had that are not covered by the above list:

_____

Patient Name _____ DOB_____

Cancellation/No Show Policy Form

Thank you for trusting your care to Signet Heart Group. When you schedule an appointment with Signet Heart Group we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective immediately any established patient who fails to show or cancel/reschedule an appointment for testing and has not contacted our office with at least 24 hours notice will be considered a No Show and will be charged a fee (the amount is determined by the test).
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact the office.

I have read and understand the Appointment Cancelation/No Show Policy and agree to its terms.

Patient's First and Last Name (Printed)

_____

Signature Date

_____ _____

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