JEFFREY C. MALUDY,
MD, FACC

Cardiology Wellness of Toledo, LLC
4417 N. Holland/Sylvania Road
Suite 301
Toledo, Ohio 43623

Phone 419 842 1100
Fax 419 842 1119
www.cardiologywellness.com

Welcome to Cardiology Wellness of Toledo, LLC
The Office of
Jeffrey C. Maludy, M.D.

_____ has been scheduled for an

Appointment at our office on _____ at _____.

Please review and complete the enclosed forms and mail them back to us with the enclosed envelope.

It is <u>important</u> that you obtain any previous cardiac testing records from your referring/primary care doctor and send them with the enclosed forms or have them faxed directly to our office. Please contact your doctor as soon as possible so we have these reports on the day of your visit.

Please bring with you ALL medications you are currently taking, as well as your Insurance card and Driver's License/Photo ID.

Our fax number is: 419-842-1119

Please call (419) 842-1100 if you have any questions.

Cardiology Wellness of Toledo
Health History

Patient Name_____ **Birthdate**_____ **Today's Date**_____

Reason for Visit _____

Cardiac Symptoms

- ☐ Chest pain
- ☐ Shortness of Breath
  - ☐ Worse with walking
  - ☐ Worse with lying down
  - ☐ Sleep in chair upright
- ☐ Palpitations: racing or skipping heartbeat
- ☐ Dizziness or Fainting
- ☐ Swelling of ankles or feet
- ☐ Murmur
- ☐ Mitral Prolapse
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure

Cardiac History (check all that apply, if known)

- ☐ Rheumatic fever
- ☐ Heart Surgery (bypass)
- ☐ Heart Valve Surgery
- ☐ Pacemaker or ICD (defibrillator)
- ☐ Heart Attack
- ☐ Coronary artery disease
- ☐ Angioplasty or Stent
- ☐ Ablation
- ☐ Neurocardiogenic syncope
- ☐ POTS

Medical History

- ☐ Diabetes
- ☐ Stroke/ TIA/ Mini-stroke
- ☐ Epilepsy
- ☐ Migraine headaches
- ☐ Thyroid disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Snoring
- ☐ Sleep Apnea (stop breathing during sleep)
- ☐ COPD
- ☐ Stomach ulcer
- ☐ Bleeding ulcer
- ☐ Hepatitis or Jaundice
- ☐ GERD or Hiatal hernia
- ☐ Kidney disease
- ☐ Cancer, Type_____
- ☐ Peripheral vascular disease (i.e. blocked arteries in legs)
- ☐ Wear oxygen/ BiPAP/ CPAP (please circle)
- ☐ HIV/ AIDS
- ☐ Other_____

Prior Cardiologist _____

Prior Cardiac Testing	Date of testing	Location of testing
☐ Stress Test	_____	_____
☐ Echocardiogram	_____	_____
☐ Holter Monitor	_____	_____
☐ TILT	_____	_____
☐ Carotid ultrasound	_____	_____
☐ Aorta duplex	_____	_____
☐ ABI	_____	_____
☐ Renal scan	_____	_____

Past Surgeries

Surgery	Date of Surgery	Hospital Performed

Review of Systems (Please check all that apply to **you**, if known)

Constitutional Symptoms
- ☐ Good General Health
- ☐ Fever
- ☐ Headaches, unusual
- ☐ Recent weight change

Genitourinary
- ☐ Blood in urine
- ☐ Change in force of urine stream
- ☐ Kidney stones

Musculoskeletal
- ☐ Arthritis
- ☐ Leg cramp with walking
- ☐ Muscle soreness

Gastrointestinal
- ☐ Indigestion
- ☐ Bitter/acid taste in throat
- ☐ Food sticking when swallowing
- ☐ Blood in bowel movement
- ☐ Black, tarry bowel movement

Eyes
- ☐ Eye disease or injury
- ☐ Wear glasses/contact lenses
- ☐ Blurred or double vision

Endocrine
- ☐ Glandular or hormone problems
- ☐ Excessive thirst or urination
- ☐ Change in hat or glove size

Integumentary (skin)
- ☐ Change in skin color
- ☐ Change in hair or nail
- ☐ Varicose veins

Neurological
- ☐ Unusual headaches
- ☐ Convulsions or seizures
- ☐ Double vision
- ☐ Unsteadiness or Falling
- ☐ Loss of vision in one eye
- ☐ One-sided weakness, numbness or paralysis

Psychiatric
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression

Hematological/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency
- ☐ Phlebitis or blood clot

Respiratory
- ☐ Chronic or frequent cough
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

Family History

Mother
- ☐ Heart disease at any age
- ☐ Heart disease in women less than 60
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congestive heart failure
- ☐ Pacemaker/Defibrillator/ICD
- ☐ Diabetes
- ☐ Stroke
- ☐ Aortic aneurysm
- ☐ Sudden death

Is she deceased? ☐ Yes ☐ No
If yes, at what age? _____
If yes, of what cause? _____

Father
- ☐ Heart disease at any age
- ☐ Heart disease in men less than 50
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congestive heart failure
- ☐ Pacemaker/Defibrillator/ICD
- ☐ Diabetes
- ☐ Stroke
- ☐ Aortic aneurysm
- ☐ Sudden death

Is he deceased? ☐ Yes ☐ No
If yes, at what age? _____
If yes, of what cause? _____

Sibling i.e. brother or sister
- ☐ Heart disease at any age
- ☐ Heart disease in **men** less than 50
- ☐ Heart disease in **women** less than 60
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congestive heart failure
- ☐ Pacemaker/Defibrillator/ICD
- ☐ Diabetes
- ☐ Stroke
- ☐ Aortic aneurysm
- ☐ Sudden death

Is he or she deceased? ☐ Yes ☐ No
If yes, at what age? _____
If yes, of what cause? _____

Patient Lifestyle Questionnaire

Height _____

Current marital status: ____Single ____Married ____Divorced ____Widowed ____Separated

Children: ____No ____Yes If yes, number of sons ____ daughters ____

Do you use tobacco? ____Never ____Former ____Year quit ____Years used
Current: ☐ Smoking ☐ Chewing ☐ Snuff Current or past use: packs per day____

Alcohol use? ____Never ____Rarely ____Socially ____Occasional ____Moderate
____Daily Amount____ Amount daily____ Years used____

Drug use/abuse? ____Never ____Current ____Former Year quit____ Type of use_____

Caffeine use? ___No ___Yes ___Coffee ___Tea ___Soda ___Chocolate Cups per day___

What type of diet do you follow? __Low salt __Low fat __Diabetic __Healthy __Junk food
__High salt __High fat __Vegetarian __None

Your daily activity level? ___Moderate ___Sedentary ___Vigorous ___Unable to exercise

Are you able to walk or run on a treadmill? ☐ Yes ☐ No

How often do you exercise? ___Never ___Daily ___Occasional ___2-3 times weekly ___3-4 times weekly

What type of exercise do you do? _____

Your current residence? ___Live alone ___Live with spouse/significant other ___Live with family member
___Nursing home ___Assisted living

Race _____ Of Hispanic or Latino ethnicity? ☐ Yes ☐ No

Religion _____ ☐ None

Do you have an advanced directive? ☐ Yes ☐ No If yes, what type? _____

What level of schooling have you completed? ___High school ___College Other_____

What is your occupation? (current or prior) _____ ☐ Retired

Do you have any known current or previous occupational hazards?

_____

Would you agree to a blood transfusion if needed? ☐ Yes ☐ No

Any recent travel? ☐ No ☐ Out of state ☐ Out of the country If yes, which state or country?_____

Medication

Pharmacy Name and Address _____

Pharmacy Phone _____ **Pharmacy Fax** _____

Mail Order Pharmacy _____

Please list **all** of your medications:

Medication Name	Dose	Instructed Use

Allergies

Medication or Food	Reaction

PATIENT INFORMATION

Patient's Full Name _____

Date of Birth_____ **Age**_____ **M F** **SS#**_____

Home Address_____ **City/State**_____ **Zip**_____

Home Phone_____ **Cell** _____

Email _____

How did you hear about us? _____

Married Single Separated Divorced Widowed
(Circle One)

Occupation (Former, if retired)_____ **Employer (Former, if retired)**_____

Spouse's Name_____ **Employed?**_____ **Where?**_____

Family Physician_____ **Address**_____
_____

Phone_____ **Fax**_____

What Pharmacy do you use? _____ **Address**_____

Pharmacy Phone_____ **Fax**_____

In case of an emergency, whom should we contact?_____

Relationship? _____ **Phone**_____

In the event that I am unable to be reached for verbal communication at my home, messages regarding my treatments and care may also be left with the following:
Message on machine: YES NO
Please List name, phone # and relation

1._____

2._____

I authorize the following named person(s) to receive my (PHI) Personal Health Information when calling the office including but not limited to test results or appointment information. Please list name, phone # and relation.

1._____

2._____

INSURANCE INFORMATION

(Our Receptionist will take copies of your cards)

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

PLEASE COMPLETELY READ THE FOLLOWING PRIOR TO SIGNING

I ASSIGN DIRECTLY TO THE PHYSICIAN ALL SURGICAL AND MEDICAL BENEFITS.

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION BETWEEN THE PHYSICIAN OF CARDIOLOGY WELLNESS OF TOLEDO, LLC AND ANY OTHER PHYSICIAN OR HOSPITAL CONCERNING MY MEDICAL CARE. I FURTHER AUTHORIZE THE RELEASE OF ANY PERTINENT MEDICAL RECORDS CONCERNING MY ILLNESS TO MY INSURANCE CARRIERS FOR REVIEW.

I UNDERSTAND THAT FROM TIME TO TIME CARDIOLOGY WELLNESS OF TOLEDO, LLC AND ITS STAFF MAY INFOR ME OF DRUGS, TREATMENT, OR OTHER SERVICES THAT MAY BE APPROPRIATE FOR MY CONDITION, AND FROM TIM TO TIME MAY INFORM ME OF NEW SERVICES THAT MAY BE APPROPRIATE FOR ME. I CONSENT TO THE USE OF M IDENTIFIABLE PATIENT INFORMATION TO NOTIFY ME OF SUCH NEW DRUGS, TREATMENTS OR OTHER SERVIC THAT MAY BE NECESSARY FOR THE CONTINUITY OF MY CARE, OR WHICH MAY BE OF BENEFIT IN MAINTAINING O IMPROVING MY HEALTH. CARDIOLOGY WELLNESS OF TOLEDO, LLC WILL NOT PROVIDE SUCH INFORMATION T OTHERS FOR MARKETING, FUND-RAISING, OR SIMILAR PURPOSES WITHOUT MY SPECIFIC CONSENT.

Patient Signature_____ **Date**_____

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Financial Payment Policy

Cardiology Wellness of Toledo, LLC
Jeffrey C. Maludy, MD, FACC

1. REGARDING INSURANCE: The doctor's service is provided directly to you and you are ultimately responsible for payment of services rendered. We do, however, participate with most insurance companies and will submit your claims on your behalf. If you have signed a Release of Information Agreement with us, the insurance payment will come directly to our office. Any "patient responsibility" amount will be billed to you approximately 30 days after your visit.

2. SPECIAL ARRANGEMENTS: There are times when making payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our billing staff or manager as soon as possible.

   Informing our patients about our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please contact our billing staff or manager.

WE ARE HERE TO HELP YOU!

I hereby understand the financial policy of this office.

_____ _____

Signature Date

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Advanced Directive Policy

(LIVING WILLS / DURABLE POWER OF ATTORNEY)

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Jeffrey C. Maludy, MD, FACC

Due to the elective nature of the tests performed in Diagnostic Imaging / Scanning, ***Advanced Directives*** are not recognized here at Cardiology Wellness of Toledo, LLC.

If however you arrive to Diagnotic Imaging / Scanning with an Advanced Directive, the document will be placed in your file in the event of a transfer and/or hospital admission. A copy of your patient file including the *Advanced Directive* document will be sent in the transfer process to the hospital.

I hereby understand and acknowledge the Advanced Directive Policy of this office.

_____ _____

Signature Date

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Compliance With HIPAA

(Health Information Portability and Accountability Act)

Dear Patient:

We understand the importance of your privacy regarding the medical care and the communications related to your care at Cardiology Wellness of Toledo, LLC.

HIPPA requires us to be in compliance with their regulations by April 15, 2003, however, please be assured that we have already taken the appropriate steps of compliance.

1. We have taken the appropriate security measures with our Internet connections.
2. Your paper charts are kept in a secure and lockable room and only accessible by our staff.
3. Computerized records can only be accessed by our staff or approved technicians.
4. Your records will not be shared with any outside entity, without your written or verbally documented approval.
5. When you visit our office we will maintain your privacy in every way possible.

If you have any questions, concerns or suggestions regarding HIPPA or patient privacy issues, please do not hesitate to call the office Monday through Friday during normal business hours.

Patients signature of acknowledgement and understand: **Date:**

_____ _____