Manshadi Heart Institute, Inc.

Setting the standard for leading-edge, results-based care

Ramin Manshadi MD, FACC, FSCAI, FAHA, FACP
Board Certified: Diagnostic and Interventional Cardiology

PLEASE PRINT CLEARLY

DATE MALE ☐ FEMALE ☐	HEIGHT WEIGHT
PATIENT NAME LAST FIRST	ALLERGIES
HOME ADDRESS	MARITAL STATUS S☐ M☐ W☐ D☐ OTHER☐
CITY STATE ZIP	DATE OF BIRTH (MONTH/DAY/YEAR)
DRIVER'S LIC. # SOCIAL SECURITY #	HOME PHONE NUMBER
PATIENT EMPLOYED BY:	CELL PHONE NUMBER
NAME OF SPOUSE	E-MAIL ADDRESS
SPOUSE'S DATE OF BIRTH	BUSINESS PHONE NUMBER
SPOUSE EMPLOYED BY:	SPOUSES BUSINESS PHONE NUMBER
PATIENT REFFERED BY:	REFERRING DR. OFFICE PHONE NUMBER
EMERGENCY CONTACT (OTHER THAN SPOUSE)	EMERGENCY CONTACT PHONE NUMBER

I, the undersigned, have insurance coverage with _____ and assign directly to Manshadi Heart Institute, Inc. All surgical and /or medical benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment benefits.

Signature _____ **Date** _____

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

Pharmacy Name_____ Phone_____

ALLERGIES To medications or substances

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates.

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____

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Acknowledgment of receipt of notice of privacy practices

I herby acknowledge that I have received a copy of the current notice will be posted in the reception area and that will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- ☐ **I would like to receive a copy of any amended Notice of Privacy Practices**

Signed _____ **Date** _____

Print name _____ **Telephone #** _____

If not signed by patient please indicate relationship:

- ☐ **Parent guardian of minor patient**
- ☐ **Guardian or conservator of an incompetent patient**
- ☐ **Beneficiary or personal representative of deceased patient**

Patient Name _____ **Date of Birth** _____

***** If you authorize another person to discuss your health history please indicate:**

Name _____ **Relationship to you** _____

Telephone # _____

Manshadi Heart Institute
Ramin Manshadi, M.D., F.A.C.C.
2633 Pacific Ave
Stockton Ca 95204
944-5530
www.drmanshadi.com

Patient name:_____

DUE TO THE HIGH DEMAND IN THE TESTING THAT WE SCHEDULE FOR OUR PATIENTS, WE WOULD LIKE TO MAKE YOU AWARE OF THE "NO SHOW" FEES FOR THE TESTS THAT ARE SCHEDULED IN THE OFFICE AS WELL AS SOME OF OUR MISCELLANEOUS OFFICE FEES

NO SHOW FEE:

$50.00 **ECHOCARDIOGRAM**

$50.00 **CAROTID ULTRASOUND**

$25.00 **ABI**

$50.00 **STRESS ECHO OR TREADMILL STRESS TEST/ T-WAVE**

$200 **NUCLEAR STRESS TEST**

$25.00 **HOLTER MONITOR NOT RETURNED THE FOLLOWING DAY/per day charge**

$2500.00 **NON RETURNED HOLTER MONITOR**

$10.00 to $25 ***FILL OUT FORM FEES, DISABILITY, FMLA, DMV, ETC***

$25.00 ***Records copy fee***

I HAVE READ AND UNDERSTAND THAT SHOULD I NEED TO BE SCHEDULED FOR ANY OF THE ABOVE TESTS AND I FAIL TO SHOW UP FOR THE APPOINTMENT, I WILL BE CHARGED THE STATED NO SHOW FEE. I MAY CANCEL 24 HOURS IN ADVANCE WITH NO CHARGE.

Patient's signature_____**date**_____