North Office
2200 Park Bend Dr.
Building 1, Suite 401
Austin, TX 78758
Phone: (512) 807-3160
Fax: (512) 339-7743

CARDIOVASCULAR SPECIALISTS OF TEXAS

Round Rock
7215 Wyoming Springs Dr
Building 1, Suite 100
Round Rock, TX 78681
Phone: (512) 807-3180
Fax: (512) 615-9908

Welcome, and thank you for choosing CST! Please tell us how you heard about us: _____

PATIENT INFORMATION

PATIENT NAME: _____ SEX: _____ DOB: _____
ADDRESS: _____ MARITAL STATUS: _____
CITY/STATE/ZIP: _____ SS#: _____
PHONE #:_____ EMAIL ADDRESS: _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Retired

Employer: _____ Occupation: _____

REFERRING PHYSICIAN: _____

ADDRESS: _____
PHONE: _____

PRIMARY CARE PHYSICIAN: _____
ADDRESS: _____
PHONE: _____

INSURANCE INFORMATION

PRIMARY: _____ SECONDARY: _____
INSURED: _____ MEMBER ID: _____
RELATION: _____ DOB: _____ GROUP: _____
MEMBER ID: _____ GROUP: _____

IN CASE OF EMERGENCY, PLEASE CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE: _____

I understand by signing this form, I acknowledge the Notice of Privacy Practices (NOPP) posted at Reception area of the CST office, and that I am able to request a copy of the NOPP from a CST Associate

_____

Signature Date

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CONFIDENTIAL HEALTH HISTORY

NAME: _____ DOB: _____

REASON YOU ARE HERE: _____

DESCRIBE THE SENSATION: _____

IF YOU ARE EXPERIENCING CHEST DISCOMFORT:
WHEN DID IT START? _____ WHEN DOES IT OCCUR? _____ HOW LONG DOES IT LAST? _____

PLEASE PROVIDE YOUR PAST MEDICAL HISTORY (INCLUDING SURGERY & HOSPITALIZATIONS):
_____

FAMILY MEDICAL HISTORY (CHECK IF YES)

FATHER:	___ LIVING?	___ HEART DISEASE?	___ STROKE?
MOTHER:	___ LIVING?	___ HEART DISEASE?	___ STROKE?
GRANDPARENTS:	___ LIVING?	___ HEART DISEASE?	___ STROKE?
BROTHER/SISTER:	___ LIVING?	___ HEART DISEASE?	___ STROKE?
AUNT/UNCLE:	___ LIVING?	___ HEART DISEASE?	___ STROKE?
CHILDREN:	___ LIVING?	___ HEART DISEASE?	___ STROKE?

OTHER HEALTH HISTORY (CHECK IF YES)

__ ABDOMINAL PAIN
__ ASTHMA
__ BLACKOUT
__ CLAUDICATION
__ CONSTIPATION
__ COUGH
__ DIZZINESS
__ EMPHYSEMA
__ EXCESSIVE THIRST
__ EXCESSIVE ANGER
__ FAINTING
__ HEAD INJURY
__ HEADACHES
__ HEARING
__ HEARTBURN
__ HEAT/COLD INTOLERANCE
__ HEPATITIS
__ INDIGESTION
__ LIVER/GALLBLADDER
__ NUMBNESS
__ PAINFUL URINATION
__ PHLEBITIS
__ PNEUMONIA
__ SEIZURES
__ SINUS PROBLEMS
__ SORE THROAT
__ URGENCY/HESITANCY
__ VARICOSE VEINS
__ VISION
__ WEIGHTGAIN/LOSS

OTHER REASONS FOR VISIT (CHECK IF YES)

__ TREADMILL TEST
__ PALPITAIONS
__ RAPID HEART BEAT
__ POOR CIRCULATION
__ SHORT OF BREATH
__ SWELLING
__ HIGH BLOOD PRESSURE
__ HEART MURMUR
__ RHEUMATIC FEVER
__ OTHER
_____
_____
_____
_____

PATIENT CARDIAC RISK FACTORS (CHECK IF YES)

__ HIGH BLOOD PRESSURE
__ SMOKING
__ OBESITY
__ CHOLESTEROL
__ DIABETES
__ FAMILY HISTORY

ALLERGIES (CHECK IF YES)

__ IODINE
__ PENICILLIN
__ SEAFOOD/SHELLFISH

SOCIAL HISTORY (CHECK IF YES)

__ *SMOKE* __ AMOUNT PER DAY __ QUIT _____DATE
__ *DRUGS* __AMOUNT PER DAY
__ *ALCOHOL* __ *CAFFEINE* __ AMOUNT PER DAY
__ DIET? _____