FACULTY PHYSICIANS, INC.

FACULTY PRACTICES OF THE UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Welcome *to University of Maryland Cardiology*

Thank you for choosing us to assist with your cardiology needs. Please read the following information to make the most of your visit to our practice.

Your appointment has been scheduled for ______________________________________
at the location checked below (please note, not all providers see patients at all locations):

☐ Charles Fisher Building, 193 Stoner Avenue, Suite 350, Westminster, MD 21157
Phone # 410-876-0086

☐ 5 Park Center Court, Suite 200, Owings Mills, MD 21117
Phone # 410-654-0400

Prior to your appointment:
Insurance and Billing information: Please obtain referrals in advance if required by your insurance carrier. Your insurance carrier can provide you with the most accurate information on your responsibility for copays and deductibles. Please complete the attached paperwork prior to your visit.

Please complete the Release of Information form if you would like to have someone other than yourself to have access to your health information on your behalf.

What you should bring to your appointment:
- Your insurance card(s)
- Photo identification
- Actual bottles of medications, both prescription and over-the-counter
- Copay and/or referral if required by your insurance company. Copays are required to be paid at time of service.

University of Maryland
Cardiology Physicians

HEALTH QUESTIONNAIRE

Patient Name:______________________________________ Date of Birth:___________________

How were you referred to this office?____

What is the reason for your visit to the cardiologist?

____

Local Pharmacy:_________________________City___________________

Mail Order Pharmacy:_________________________

Medication Allergies:____

Current medications: Please list name, strenghth and how often you take them.
Be sure to include all over the counter medications and supplements.

______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________

List your present and past medical history of illness

____

____

____

List your past surgical history: Type of surgery and date

____

____

____

Social History

Your occupation?______________________________________ Education level:__________

Marital Status?______________________

How many children do you have?__________________________

Yes No History of Smoking? If yes, ______packs/day for ____years. Date quit if applicable_____
History of Chewing Tobacco? If yes, _______ amt/day. Date quit if applicable________

Yes No Consume alcohol? If yes, how many servings ______/day __________week

Yes No Do you use any illicit drugs?____________________________________

Yes No Do you use any ambulatory devices (cane, walker, wheelchair)?_________________

Yes No Do you exercise ? If yes, how often per week?________________________________

Yes No Do you consume Caffeine drinks? If so how many per day______________________

Family History- Please check

	Mother	*Father*	*Sisters*	*Brothers*
Anemia				
Arrhythmia				
Asthma				
Cancer				
Depression				
Diabetes				
Heart Attack				
Heart Failure				
High Cholesterol				
Hypertension				
Kidney Disease				
Sudden Death				
Stroke				
Fainting				
Thyroid Disease				

□ Adopted

Father
□ Alive
□ Deceased

Mother
□ Alive
□ Deceased

Sisters
Total Alive _____
Total Deceased _____

Brothers
Total Alive _____
Total Deceased _____

Mark Yes or No if you currently have any of the problems below today.

□ No	□ Yes	Fever, Chills, Diaphoresis	□ No	□ Yes	Flank pain or involuntary urination
□ No	□ Yes	Ear pain, Facial Swelling	□ No	□ Yes	Skin color changes
□ No	□ Yes	Runny Nose, Postnasal drip	□ No	□ Yes	Seizures, Facial numbness
□ No	□ Yes	Eye discharge, itching, visual changes	□ No	□ Yes	Enlarged lymphnodes
□ No	□ Yes	Problems with choking or wheezing	□ No	□ Yes	Suicidal ideas, Behavioral problems
□ No	□ Yes	Abdominal distention	□ No	□ Yes	Confusion

Reviewed by: ________________________________

____
Date: