

**NEW PATIENT INFORMATION**



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Wassim Shaheen, M.D.      Ghiyath Tabbal, M.D.      Saad Z. Farhat, M.D.  
Madan Acharya, M.D.      Peeyush Grover, M.D.

Date: \_\_\_\_\_

Dear: \_\_\_\_\_

You are scheduled for an appointment with:

Dr. \_\_\_\_\_

**Location:**      **3535 N. Webb Road, Wichita, KS 67226**

**Phone:**      Heartland Cardiology: 316-686-5300

**Date:** \_\_\_\_\_

**Time:** \_\_\_\_\_

1. Please complete the enclosed forms and bring them with you to your appointment.
2. Please bring your insurance card(s) AND photo ID to your appointment.
3. **Bring all medications you are currently taking, in the bottles.**
4. **It is very important that we have your past pertinent medical records.** Please verify that these records are being mailed or faxed to our office from your referring physician’s office prior to your appointment. This allows our physician to review your records prior to your appointment.
5. If you are a member of a managed health plan such as Coventry HMO/POS, AETNA, CIGNA, TriCare, or UHC Compass, you will need to obtain a written referral from your primary care physician. You may verify in advance that your referring physician’s office is taking care of any necessary referrals. If you have any questions, please contact our office for assistance.
6. **If you are a member of any insurance plan that requires a written referral and you do not obtain authorization from your primary care physician prior to your visit, you will be responsible for all charges at this appointment.**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Place of Employment: \_\_\_\_\_

Primary Care

Doctor: \_\_\_\_\_

Referring

Doctor: \_\_\_\_\_

Are you currently seen by another Cardiologist? Yes/ No

If yes, please provide name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: Married Single Divorced Widowed

Race/Ethnic Group: \_\_\_\_ American Indian/Alaskan \_\_\_\_ Asian/Pacific Islander

\_\_\_\_ Black/African American \_\_\_\_ Caucasian/White \_\_\_\_ Hispanic \_\_\_\_ Other

Primary

Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Relationship: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**Medications** (Name, Dose, How Often) Please list heart-related medications first:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**Medical History: Please circle all that apply**

High Blood Pressure / Heart Attack / Stroke / High Cholesterol / Diabetes / Coronary Artery Disease

Palpitations / Dizziness / Shortness of Breath / Irregular Heartbeat / Leg Swelling / Leg Pain

Other Medical History: \_\_\_\_\_

Allergies/Intolerances: \_\_\_\_\_

**Surgical History**

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**Family History (Please check all boxes that apply)**

Family Member	Living?	Age	Heart Attack	Hypertension	Diabetes	CVA	Mental Illness	Cancer	Ventricular Dysfunction
Father									
Mother									
Sibling									
Sibling									

**Social History**

Alcohol Consumption: YES / NO      How much/How Often: \_\_\_\_\_

Recreational Drug Use: YES / NO      Drug name/How Often: \_\_\_\_\_

Caffeine: YES / NO Type/Amount/How Often: \_\_\_\_\_

Marital Status: Married   Single   Divorced   Widowed

Occupation: \_\_\_\_\_

Exercise: YES / NO      Type/How Often: \_\_\_\_\_

Smoker: YES / NO/ Former      Type/How long: \_\_\_\_\_      Interested in Quitting? YES / NO

\* FORMER Smoker: How much did you smoke?: \_\_\_\_\_ How long ago did you quit?: \_\_\_\_\_

Other Medical Conditions Not Listed Above:

\_\_\_\_\_  
\_\_\_\_\_



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Do you have any of the following symptoms?**

YES NO Chest pain

YES NO Shortness of Breath  
Mild Activity Moderate Activity Severe Activity

YES NO Dizziness

YES NO Palpitations

YES NO Swelling in legs/feet

YES NO Leg cramps  
Mild Activity Moderate Activity Severe Activity

Do you lay flat to sleep? YES / NO

How many pillows do you use at night? \_\_\_\_\_

Do you wake up at night gasping for air? YES/NO

Energy Level GOOD/ FAIR/ POOR

Do you have any cardiac concerns? YES / NO If yes, please explain

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