

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____			Birthdate: _____		
Last	First	MI			
Patient's Address: _____					
Street		City	State	Zip	
Patient's Telephone Number (____) - _____					

This will authorize my **Primary Care Clinic/MD:** _____
(Print Name of Clinic/MD)

To release the following medical information:

- | | |
|---|---|
| <input checked="" type="checkbox"/> History & Physical | <input checked="" type="checkbox"/> EKG |
| <input checked="" type="checkbox"/> Clinical Summary | <input checked="" type="checkbox"/> Laboratory results |
| <input checked="" type="checkbox"/> Procedure/Operative Reports | <input checked="" type="checkbox"/> Stress Test/Treadmill Reports |
| <input checked="" type="checkbox"/> Consultation Reports | <input checked="" type="checkbox"/> Echocardiogram Reports |
| <input checked="" type="checkbox"/> Physician Progress Notes | <input checked="" type="checkbox"/> Stress Echocardiogram Reports |
| | <input checked="" type="checkbox"/> Holter Monitor (include EKG tracings) |

This information is needed for the following purpose(s): **Cardiology appointment at Minnesota Heart Clinic.**

6405 France Ave So, Suite W200, Edina MN 55435. Fax number: (952) 836-3950.

***This authorization will remain in effect a maximum of twelve (12) months from the date of signature and may be canceled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy or facsimile of this authorization will be treated in the same manner as the original.**

Signature of Patient/Parent/Guardian

Relationship to Patient

Reason Patient is Unable to Sign

Witness

DATE _____

PLEASE PRINT

Patient Name:

Last	First	Middle Initial
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Date of Birth: _____ **Sex:** M F **Social Security #** _____

Marital Status: Single Married Divorced Separated Widowed

Religion: _____ **Language:** _____ **Race:** _____

Employment Status: Full-time Part-time Self-Employed Retired Student Active Military Duty Other

Home Address:-

City: _____ **State:** _____ **Zip Code:** _____ **Home Phone:** _____

Cell Phone: _____

Employer Name: _____ **Work Phone:** _____

Employer Address: _____

Referring Physician & Clinic Name: _____

Emergency Contact: _____ **Phone Number:** _____

Insurance Information: Please bring your Insurance card(s) to your appointment.

Primary Insurance: _____

Group #: _____ **Contract ID#:** _____

Subscriber: _____ **DOB:** ___/___/___ **Relationship to Subscriber:** _____

Subscribers Employer: _____

Secondary Insurance: _____

Group #: _____ **Contract ID#:** _____

Subscriber: _____ **DOB:** ___/___/___ **Relationship to Subscriber:** _____

Subscribers Employer: _____

MN Heart Clinic Patient History Form

Name _____ Age _____ Today's Date _____

Birthdate _____ Marital Status S M W D Number of Children:

Primary Care Physician _____ Date of last Physical Exam _____

Reason for Visit Today _____

Family History

	Has this relative had any of the following? Diabetes; Heart Attack, High Blood Pressure, Stroke, Heart Problems, High Cholesterol	Living Y/N	Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				

Personal History

Current Medical Problems

Previous Medical Problems/Surgeries

When

Cardiac Risk Factors

Have you been diagnosed with:

High Blood Pressure ()

High Cholesterol ()

Diabetes ()

How much do you have each **day** of:

Caffeine: Coffee Tea Soda/Pop Quantity _____

Tobacco: Cigarette Cigar Pipe Quantity _____

Alcohol: Beer Wine Hard Liquor Quantity _____

Do you exercise regularly: Yes No

If yes, what type of exercise? _____ How often? _____

What type of diet do you follow? _____

Allergies

Drug or Food	What is your reaction?

Current Medication (Prescribed and Over the Counter)

Name of Medicine	Dose	How often?

Name of Medicine	Dose	How Often?

A review of how you have been feeling lately.

General

- Weight loss () No () Yes
- Weight gain () No () Yes
- Fever or chills () No () Yes
- Changes in exercise tolerance () No () Yes

Skin

- Change in hair or nails () No () Yes
- Rashes () No () Yes
- Skin lesions () No () Yes

Eyes

- Double vision () No () Yes
- History of glaucoma () No () Yes
- Visual field defects () No () Yes

Ears, Nose, Mouth, Throat

- Hearing loss () No () Yes
- Nose bleeds () No () Yes
- Hoarseness () No () Yes
- Difficulty speaking () No () Yes

Respiratory

- Shortness of breath () No () Yes
- Cough () No () Yes
- Wheezing () No () Yes
- Sleep apnea () No () Yes

Heart

- Palpitations () No () Yes
- Chest pains () No () Yes
- Difficulty breathing lying down () No () Yes
- Waking at night short of breath () No () Yes

Gastrointestinal

- Blood in stool () No () Yes
- Dark stools () No () Yes
- Diarrhea () No () Yes
- Constipation () No () Yes

Hematological/Immunologic

- Food/seasonal allergies () No () Yes
- Bleeding Tendency () No () Yes
- Increased bruising () No () Yes

Gynecologic

Date of LMP: _____

Hormone Replacement Therapy

- Currently: () No () Yes
- In the Past: () No () Yes

If Yes, duration: _____

Number of pregnancies _____

Type of Delivery:

- Vaginal () No () Yes
- Cesarian () No () Yes

Pregnancy Complications:

- Pre-eclampsia () No () Yes
- Diabetes during pregnancy () No () Yes
- Cardiomyopathy () No () Yes
- Other () No () Yes

Kidney

- Painful urination () No () Yes
- Getting up at night to urinate () No () Yes
- Frequent urination/Urgency () No () Yes
- Blood in urine () No () Yes
- Erectile Dysfunction (ED) () No () Yes

Musculoskeletal

- Swelling of legs () No () Yes
- Swelling of the ankles () No () Yes
- Arthritis () No () Yes
- Back problems () No () Yes

Neurological

- Recurrent strokes () No () Yes
- TIA () No () Yes
- Seizure disorder () No () Yes

Psychiatric

- History of depression () No () Yes
- History of substance abuse () No () Yes
- Change in memory () No () Yes

Endocrine

- Heat/Cold intolerance () No () Yes
- Increased thirst () No () Yes
- Increased urination () No () Yes