PROVIDENCE
Medical Group
Hood River

Columbia Gorge Heart Clinic
1108 June St.
Hood River, OR 97031
541-387-6125 | fax 541-387-6315

Appointment date/time _____

Physician _____

Welcome to the Columbia Gorge Heart Clinic. We welcome you as a patient and thank you for choosing us to participate in your health care.

Because you are important and deserve quality time with your doctor, please arrive 40 minutes prior to your scheduled appt to complete registration process and visit with a nurse. Additionally, we ask that you bring all medications you are currently taking, including supplements and over-the-counter medications, in the original bottles, so that they charted correctly upon your initial visit.

Patient history:
Please request the chart notes from your last visit with your primary care physician and history of specialty care including labs and X-rays (EKG, echocardiograms, and cardiac studies) and information on heart surgeries, catheters or other procedures. Patient history information should be faxed to the clinic as soon as possible.

Please see the enclosed information regarding your first appointment.

**We request that you refrain from wearing perfumes or colognes, as we see many patients who are susceptible to allergic reactions to scents.**

Please bring the following to your appointment:

- Photo ID
- Medical insurance card
- Completed enclosed forms
- All current medications, in the original bottles

If you have any questions, please call us at 541-387-6125.

We look forward to seeing you soon.

PROVIDENCE
Medical Group
Hood River

Columbia Gorge Heart Clinic
1108 June St.
Hood River, OR 97031
541-387-6125 | fax 541-387-6315

**History form:**
Please fill out your medical history as completely as possible.

**Medications:**
Please bring in all your current medications in the original bottles.

**Record release form:**
If you are transferring from another care provider, please request your records be transferred to your new doctor before to your appointment. You will find this form, Authorization for Release of Medical Records, in your packet.

If you need a copy of your lab results, you can sign a two-year release of records in your physician's office.

**Cancellation policy:**
We ask that you contact our office at least 24 hours before to your scheduled appointment if you need to cancel or reschedule. This allows appointments for other patients.

**Before your appointments:**
Please arrive 40 minutes before your scheduled appointment to allow time for registration. Remember to transfer your medical records from your previous provider.

**Notice:**
If you arrive more than 10 minutes past your scheduled appointment time, you may be asked to reschedule your appointment.

**Billing Questions: 541-387-8219 or 877-215-7833**

PROVIDENCE Medical Group Hood River

**COLUMBIA GORGE HEART CLINIC - PATIENT HISTORY FORM**

Today's Date_____/_____/_____

Last Name_____First Name_____Middle_____

Date of Birth _____/_____/_____

CHIEF COMPLAINT - Briefly describe the main reason for your visit today.

_____

_____

Have you been diagnosed with? (Please circle all that apply)

Diabetes High Blood Pressure High Cholesterol

Are you a current or former cigarette smoker? Y or N Current Former

**GENERAL HEALTH AND HABITS**

**EXERCISE**

Do you exercise regularly? Yes_____ No_____
How long have you exercised on a regular basis? _____ Years
Type Of exercise's)_____ How Often?_____days/week,for_____ Minutes.

**SMOKING**

Do you smoke? Yes_____ Never_____ Quit_____
How many per day?_____ How many years?_____
What do you smoke? Cigarettes_____Pipe_____ Cigars_____Other (specify)_____
If you no longer smoke, when did you quit?_____
If you no longer smoke, how long did you smoke and how heavily?_____

**ALCOHOL/BEVERAGES**

Do you drink alcohol? Yes_____ No_____
If yes, estimate the amount of drinks/beers: Per day_____ Per week_____
Did you formerly drink alcohol but have permanently stopped? Yes_____ No_____
Estimate the amount of caffeinated beverages (coffee, tea,cola) you drink per day_____glasses, cups, cans

**SOCIAL HISTORY**

What is your marital status_____ If married, for how long?_____
Do you have any children? Yes_____ No_____ If yes, how many?_____
Are you currently employed? Yes_____ No_____ What is your occupation?_____
If no longer employed or retired, what was your occupation?_____

**MEDICATIONS**

Are you allergic to any medications, Iodine, or shellfish? Yes_____ No_____
If yes, please list the name and the reaction _____
_____
_____
_____

Nursing staff must review your medications, vitamins and supplements at your appointment. Please bring all of your current medication bottles with you for accuracy.

**Reviewed by : Signature of Physician**_____ **Date**_____

**PAST MEDICAL AND SURGICAL HISTORY**

List all **surgeries** that you have had, date and hospital if known.

| Operation | Hospital and City | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List all **hospitalizations** not related to surgical procedures. **Do not include childbirth.**

| Reason for Hospitalization | Hospital and City | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had sedation or anesthesia before? Y or N

If yes, list any problems? _____

Have you ever had IV contrast before? Y or N

If yes, list any problems? _____

**FAMILY HEALTH:** Specifically, any direct blood relative ( grandparents, mother, father, sister, brother)

Have any of the above family members been diagnosed with heart disease? Y or N

If yes, please circle which family member(s)

grandparent mother father sister brother

Have any of the above family members been diagnosed with diabetes? Y or N

If yes, please circle which family member(s)

grandparent mother father sister brother

Have any of the above family members been diagnosed with disease of the arteries or veins? Y or N

If yes, please circle which family member(s)

grandparent mother father sister brother

Have any of the above family members been diagnosed with a TIA or stroke? Y or N

If yes, please circle which family member(s)

grandparent mother father sister brother

Have any of the above family members been diagnosed with high blood pressure? Y or N

If yes, please circle which family member(s)

grandparent mother father sister brother

Have any of the above family members been diagnosed with high cholesterol? Y or N

If yes, please circle which family member(s)

grandparent mother father sister brother

**Reviewed by : Signature of Physician**_____ **Date**_____

**PROVIDENCE HEART CLINIC - SYSTEM REVIEW FORM**

Do you **NOW** have any problems related to the following systems? Circle Yes or No

**CARDIOVASCULAR (HEART)**

| | |
|---|---|
| Chest Pain | Y or N |
| Heart trouble | Y or N |
| Heart attack | Y or N |
| Angina pectoris | Y or N |
| High cholesterol | Y or N |
| High blood pressure | Y or N |
| Fainting | Y or N |
| Racing of heart | Y or N |
| Rheumatic fever | Y or N |
| Heart failure | Y or N |
| Abnormal EKG | Y or N |
| Swelling of ankles | Y or N |
| Leg cramps | Y or N |

**RESPIRATORY (LUNGS)**

| | |
|---|---|
| Wheezing | Y or N |
| Frequent cough | Y or N |
| Shortness of breath | Y or N |
| Disruptive Snoring | Y or N |
| Breathing Pauses | Y or N |
| Excessive Daytime Sleepiness | Y or N |
| Other _____ | Y or N |

**ENDOCRINE**

| | |
|---|---|
| Hormone problems | Y or N |
| Thyroid disease | Y or N |
| Diabetes | Y or N |
| Osteoporosis | Y or N |
| Other _____ | |

**GENITOURINARY**

| | |
|---|---|
| Urine retention | Y or N |
| Painful urination | Y or N |
| Urinary frequency | Y or N |
| Other _____ | |

**HEMATOLOGICAL/LYMPHATIC**

| | |
|---|---|
| Swollen glands | Y or N |
| Blood clotting problem | Y or N |
| Other _____ | |

**INTEGUMENTARY (SKIN)**

| | |
|---|---|
| Skin rash | Y or N |
| Other _____ | |

**PSYCHIATRIC**

| | |
|---|---|
| Memory Loss or confusion | Y or N |
| Depression | Y or N |
| Sleep Problems | Y or N |
| Other | Y or N |

**GASTROINTESTINAL**

| | |
|---|---|
| Poor appetite | Y or N |
| Trouble swallowing | Y or N |
| Heartburn | Y or N |
| Nausea or vomiting | Y or N |
| Abdominal pain | Y or N |
| Constipation | Y or N |
| Diarrhea | Y or N |
| GI bleeding | Y or N |
| Other _____ | |

**CONSTITUTIONAL SYMPTOMS**

| | |
|---|---|
| Fever | Y or N |
| Chills | Y or N |
| Headache | Y or N |
| Weight gain | Y or N |
| Weight loss | Y or N |
| Other _____ | |

**EYES**

| | |
|---|---|
| Blurred vision | Y or N |
| Double vision | Y or N |
| Pain | Y or N |
| Other _____ | |

**ALLERGIC/IMMUNOLOGIC**

| | |
|---|---|
| Hay fever | Y or N |
| Drug allergies | Y or N |
| Other _____ | |

**NEUROLOGICAL**

| | |
|---|---|
| Stroke | Y or N |
| TIA - Mini stroke | Y or N |
| Dizzy spells | Y or N |
| Numbness/Tingling | Y or N |
| Other _____ | |

**EARS/NOSE/THROAT/MOUTH**

| | |
|---|---|
| Ear infection | Y or N |
| Sore throat | Y or N |
| Sinus problems | Y or N |
| Other _____ | |

**MUSCULOSKELETAL**

| | |
|---|---|
| Joint pain | Y or N |
| Neck pain | Y or N |
| Back pain | Y or N |
| Other _____ | |

**Reviewed by : Signature of Physician**_____ **Date**_____

# Others Involved in Your Health Care

PROVIDENCE Medical Group Hood River

This office requires a signed release to give any information regarding appointments, test results, health status, etc. to others. Anyone not listed on this form will not be given any information without a separate, specific release signed by the patient or legal representative.

**Please note:** Patients are no longer considered minors after age 17. If a patient over the age of 17 wishes to release information to a parent or guardian, they must include the name and relationship of that person on this form. Information will not automatically be given because a patient resides with his or her parent(s) or guardian(s).

Medical information is to be released to:

| Name | Relationship | Phone number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

_____ _____

**Patient name [Print]** **Date of birth**

_____ _____

**Authorized signature** **Today's date**

_____ _____

**Legal representative if not patient [Print]** **Relationship**

**MR#** _____

# Authorization for Release of Medical Records

PROVIDENCE Medical Group Hood River

**Patient's Name:** _____
*First* *Middle* *Last*

**Date of Birth:** ____/____/____ **Social Security Number:** _____

| PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION | |
|---|---|
| **FROM:** | Name (Medical Provider holding records): _____<br>Address: _____ |
| **TO:** | Name: Phone #<br>Address: Fax # |

The purpose of the release is: ❑ Diagnostic Evaluation ❑ Reimbursement ☑ Follow-Up Care ❑ Legal ❑ Other

The following information may be released: ☑ Clinical notes (Re: _____)

☑ Laboratory Reports ( LAST 2 YEARS) ☑ Immunization Records ☑ Medication Records ☑ X-Ray Reports

☑ Other: EKG'S, PATHOLOGY REPORTS, SPECIAL STUDIES, SPECIALISTS' CONSULTS, HOSPITAL RECORDS INCLUDING ER VISITS, ADMITS, H&P'S, IN PT. CONSULTS, SURGERY/PROCEDURE REPORTS, AND DISCHARGE SUMMARIES (LAST six MONTHS ONLY)

Information may be released for dates of service from SEE ABOVE through SEE ABOVE

This authorization expires six months from the date signed or: _____ (specified expiration date)

**I have read the above and fully understand its contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.**

_____ _____
(Signature of patient or representative) Relationship (if signed by representative)

_____ _____
Date Signed Witness (optional)

**Driver's License/Identification** _____

| | |
|---|---|
| I do ____/do not ____ specifically consent to transmission of my medical records via a facsimile (fax) machine.<br>Signature Date | I recognize that the information disclosed may contain drug/alcohol information that is protected by Federal and State law. I specifically consent to disclosure of such information<br>Signature Date |
| I recognize that the information disclosed may contain mental health information that is protected by Federal and State Law. I specifically consent to disclosure of such information<br>Signature Date | I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV / AIDS testing information. I specifically consent to disclosure of such information<br>Signature Date |

This authorization may be revoked at any time unless prior action has been taken as a result of this form. Records obtained as authorized by this consent for information release will be maintained in accordance with Federal confidentiality regulations (Title 42 of the Federal Register) which prohibits re-disclosure.

**Medical Record #** _____

# Providence
# Prescription Refill Policy

PROVIDENCE
Medical Group
Hood River

Columbia Gorge Heart Clinic
1108 June St.
Hood River, OR 97031
541-387-6125 | fax 541-387-6315

Please request **all** prescription refills through your pharmacy:

- Your pharmacy's phone number and your prescription number should be on your prescription bottle.
- Call your pharmacy even if you have no refills remaining. Your pharmacy will contact your doctor for authorization.
- If you are changing pharmacies, your new pharmacy can contact your previous pharmacy and transfer your existing prescriptions. Your new pharmacy will contact our office if refills are needed.

Call your doctor's office for a refill **only** if:

- Your prescription needs to be picked up in person.
- You have a question about your medication.

Please allow at least 72 hours to approve your refill request, as our refills are processed by a central refill service in Portland.