Phelps Memorial Specialty Clinic
1215 Tibbals St.
Holdrege, NE 68949
P: 308.995.3334
F: 308.995.2855

OUTREACH NEW PATIENT INTAKE

Name: _____

DOB: _____

Reason for Visit: _____ Email: _____

Primary Care Provider: _____

Pharmacy Name:_____ Location:_____ Local or Mail Order? (Circle One)

(PREFERRED PHARMACY SHOULD BE LISTED ABOVE WHERE MEDS SHOULD BE CALLED INTO FOR TODAY'S VISIT)

- ☐ Have you ever had a Heart Attack? **YES or NO** Date: _____ Location of Hospital: _____
- ☐ Ever had heart surgery? (Coronary artery bypass surgery or valve surgery?) YES or NO, If so, where? _____
- ☐ **Do you have Angina, Chest Pain, or Chest Discomfort?**
  - Description (dull, sharp, pressure, tightness, ache, burning, heaviness)?
  - Location (chest, neck, arms, back, jaw, abdomen)?
  - Does it radiate anywhere (arms, neck, throat, jaw, back)?
- ☐ **Do you have Shortness of Bre**ath? **YES or NO**
- ☐ **What activities is this associated with?**
  - What relieves it?
  - How often does it happen?
  - How long does it last?
- ☐ **Do you have dizziness/feeling lightheaded? YES or NO**
- ☐ **Have you passed out/blacked out? YES or NO**
- ☐ **Do you notice irregular heartbeats? YES or NO**
- ☐ **Do you get palpitations? YES or NO**
- ☐ **Do you use a CPAP? YES or NO**
- ☐ **HAVE YOU EVER HAD?**
  - Abnormal heart rhythm? Atrial Fibrillation?
  - Ankle Swelling?
  - Heart failure?
  - Rheumatic fever?
  - Leg cramps when you walk?
- ☐ **Do you have any of the following risks for heart disease?**
  - High Blood Pressure?
  - Diabetes Mellitus
  - High Cholesterol
  - Tobacco Use
  - Any Family Members with Heart Disease? **YES or NO**
- ☐ **Have you ever had any of the following? (CIRCLE BELOW ALL THAT APPLY WITH LOCATION/DATE)**
  - A Stress Test
  - An Echocardiogram
  - Cardiac Catheterization/Heart Cath
  - Coronary Angioplasty
  - Coronary Bypass Surgery
  - Valve Surgery
  - An Electrophysiology Study or Procedure
  - Any Vein procedures
  - A Pacemaker or Defibrillator? Brand: _____

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Past Medical History:

Have you ever been **diagnosed** with any of the following conditions or had any of the procedures listed below? *Check Yes or No. If yes, please give an explanation.*

CARDIOVASCULAR HISTORY			**Comments:**
Atrial Fibrillation	☐**YES**	☐**NO**	
Blood Clotting Disorder	☐**YES**	☐**NO**	
Carotid Artery Disorder	☐**YES**	☐**NO**	
Congestive Heart Failure	☐**YES**	☐**NO**	
Elevated Cholesterol	☐**YES**	☐**NO**	
Heart Murmur	☐**YES**	☐**NO**	
Heart Surgery/Angioplasty	☐**YES**	☐**NO**	
High Blood Pressure	☐**YES**	☐**NO**	
Prosthetic/Artificial Heart Valve	☐**YES**	☐**NO**	
Blockage of Arm or Leg Blood Vessels	☐**YES**	☐**NO**	
Endocarditis	☐**YES**	☐**NO**	
Diabetes	☐**YES**	☐**NO**	
Thyroid Disease	☐**YES**	☐**NO**	
Blood Clot in Lung	☐**YES**	☐**NO**	
OTHER HEALTH HISTORY			
Stomach Ulcers	☐**YES**	☐**NO**	
Liver Disease/Hepatitis	☐**YES**	☐**NO**	
Kidney/Bladder Disease	☐**YES**	☐**NO**	
Lung Disease	☐**YES**	☐**NO**	
Tuberculosis/COPD/Asthma	☐**YES**	☐**NO**	
MRSA Infection	☐**YES**	☐**NO**	
Alcohol Dependency	☐**YES**	☐**NO**	
Cancer	☐**YES**	☐**NO**	
Drug Abuse	☐**YES**	☐**NO**	
Immune System Disorders	☐**YES**	☐**NO**	
Toxic Exposure	☐**YES**	☐**NO**	
Sexually Transmitted Disease	☐**YES**	☐**NO**	

Surgical History/Previous Operations/Hospitalizations: (Please use back of page if more room is needed)

Date:	Hospital:	Problem/Operation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any immediate family who has a history of heart disease? If so, whom? _____

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Allergy History:
Have you ever had an allergic reaction to any Medications? ☐**YES** ☐**NO** If yes, please list the medication and **REACTION** below.

Do you have a Latex Allergy? ☐**YES** ☐**NO** Do you have an allergy to IV Dye/Contrast? ☐**YES** ☐**NO**

Social History:
Have you ever smoked cigarettes? ☐**YES** ☐**NO** Vape? ☐**YES** ☐**NO** Age started smoking: _____

If yes, how much do you currently smoke per day? _____ What year did you quit? _____

Are you exposed to secondhand smoke? ☐**YES** ☐**NO**

Do you chew tobacco? ☐**YES** ☐**NO** How much do you chew?_____

Do you use drink alcohol? ☐**YES** ☐**NO** Type _____ How much/often? _____

Do you use other drugs (i.e., marijuana, meth, cocaine, etc.)? ☐**YES** ☐**NO**

Do you drink caffeine (i.e., coffee or soda)? ☐**YES** ☐**NO**

Do you exercise? ☐**YES** ☐**NO** What kind of exercise? _____

(HAVE A COPY OF MEDICATION LIST READILIY AVAILABLE FOR STAFF)

NURSING STAFF TO COMPLETE VITAL SIGNS

HT: _____ WT: _____ TEMP: _____ BP: _____/_____ PULSE: _____ RESP: _____ O2: _____