Metropolitan Heart & Vascular Institute

Thank you for scheduling an appointment at Metropolitan Heart and Vascular Institute. We are looking forward to meeting you. Enclosed are our patient registration forms. Please complete these forms to the best of your knowledge and bring them with you on the day of your appointment.

Medical Records: It is very important that we have information regarding your past medical and cardiac care. This includes any procedures, surgeries, labs, EKG's, imaging studies or office visits. We request any films be sent on CD-ROM. Your records can be faxed to us at 763-427-0904.

If you are an Allina Medical Clinic (AMC) patient, your records are already available to us through your electronic medical record. If you are not an AMC patient, please arrange to have your records sent to us. In addition, we would like you to fill out the Health Information Worksheet, Family History form and your medication list that are enclosed. Having these forms completed prior to your visit will help expedite the check in process.

Insurance: Please bring your current insurance card(s) with you to your appointment. If your insurance plan requires a co-pay, it will be due at the time of service. If your insurance plan requires a ***referral,*** you are responsible for obtaining this referral from your primary care provider/clinic prior to your appointment.

Scheduling and Punctuality: We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. From time to time, a patient emergency arises and we may be running late for your visit, if this occurs, you will have the option to re-schedule or stay to be seen.

We understand circumstances may arise which make it impossible for you to keep a scheduled appointment. Should this happen in the future, call us as soon as you know the appointment will be missed. The earlier you let us know, the more likely we can offer your scheduled appointment time to another patient. If you need to cancel your appointment, we request at least a 24 hour notice. To cancel your appointment please call 763-427-9980.

What to Expect: The first time you come in we will be gathering information regarding your previous care and your current situation and/or symptoms. We will not be doing any testing on that day. The physician will determine which test you may need and how urgent they are.

If your cardiac provider prescribes you medications it is important that you see us yearly so we can make sure you are safe and receiving the proper dosage of medication. When you are down to one refill on your medication, we ask that you call and schedule your follow-up office visit in order to be evaluated and have your medications adjusted or refilled. Please allow enough time for us to make an appointment so you're not without your medication.

If you have any further questions or believe you will be unable to get the requested information in a timely fashion, please call our main switchboard at 763-427-9980 and we will be happy to assist you.

We are looking forward to meeting with you and assisting in your cardiac care.

Thank you,

Metropolitan Heart and Vascular Institute

Nursing Staff

Metropolitan Heart & Vascular Institute

Health Information Worksheet: Name: _____

Please bring your up-to-date (latest) medication list OR all your medication bottles to your clinic visits.

General

Have you experienced an unexplained weight loss of greater than 10 pounds in

the past three months? _____Yes _____No

Have you experienced an unexplained weight gain of more than 10 pounds in

the past three months? _____Yes _____No

Do you have or have you had cancer? _____ Yes _____No

Respiratory

Do you have a cough? _____Yes _____No

Do you wheeze? _____ Yes _____No

Do you have lung disease? _____ Yes ____ No

If so, which do you have? Asthma _____ COPD _____ Emphysema _____

Cardiovascular

Do you experience chest pain? _____ Yes _____No

Do you experience shortness-of-breath with exertion or activity? (dyspnea) _____ Yes _____No

Does your heart race, skip beats, or beat irregularly? (palpitations) _____ Yes _____No

Have you passed out or lost consciousness in the past year? (syncope) _____ Yes _____No

Do you experience swelling in your legs or ankles? (edema) _____ Yes _____No

Do you experience cramping or aching in your calves or legs with walking? (claudication) _____ Yes _____No

Gastrointestinal

Do you have blood in your bowel movements? _____ Yes _____No

Have you vomited blood within the last six months? _____ Yes _____No

Do you have abdominal pain AFTER eating? _____ Yes _____No

Do you have trouble with any of the following?

heartburn _____, reflux _____, GERD _____ or ulcers _____? _____ Yes _____No

OVER

Genitourinary

Do you have blood in your urine? _____ Yes ____ No

Do you have kidney disease or kidney failure? _____ Yes _____No

Neurological

Have you ever had a stroke _____, paralysis _____, mini-stroke _____, TIA _____? _____ Yes _____No

Do you have a problem with dizziness _____ or fainting _____? _____ Yes _____No

Have you had any problem with speaking – such as garbled speech _____

or difficulty with word finding _____? _____ Yes _____No

Eye

Have you had any vision changes within the last six months? _____ Yes _____No

Ear, Nose and Throat

Do you experience any ringing in your ears? _____ Yes ____ No

Do you experience vertigo? (dizziness) _____ Yes _____No

Musculoskeletal

Do you have arthritis? _____ Yes ____ No

Do you have muscle aches? _____ Yes ____ No

Skin

Do you have a skin rash _____ or skin condition _____? _____ Yes ____ No

Psychological

Do you have depression or a history of depression? _____ Yes _____No

Do you have dementia? _____ Yes _____ No

Endocrine

Do you have a thyroid problem? _____ Yes _____ No

Do you have diabetes? _____ Yes _____No

Patient Family History

Metropolitan Heart & Vascular Institute
4040 Coon Rapids Blvd, Coon Rapids, MN 55433
763-427-9980

Family Status	Alive	Good Health	Deceased	Age of Death
Mother				
Father				
Sister/s (#____)				
Brother/s (#____)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Children (Son#____ /Daughter#____)				
Other:				

Family Conditions	Mother	Father	Sister	Brother	Other (Please list relation)
Alcohol Addiction/Drug Abuse					
Problems with Anesthesia					
Arthritis					
Asthma					
Blood Disorder					
Diabetes					
Genetic Disorder					
Stomach/GI Issues					
Bladder/Kidney disease					
High Blood Pressure					
Coronary Heart Disease/ Heart Attack					
High Cholesterol					
Psychiatric Issues/Mental Illness					
Stroke					
Seizure Disorder					
Thyroid Disorders					
Cancer – Type:					
Other:					
Other:					

Medication List

Please list all medications you are currently taking
Including any prescriptions. Over –the-counter medications. Herbs. Supplements

Name	Dosage	When do you take it

List any allergies to medication and the symptoms:

Medications	Symptoms

Name of Pharmacy you would like prescriptions sent to:
Address:
Phone Number: