Dear New Patient -

Please fill out these forms as completely as possible. If you need help filling them out because you don't understand them, have trouble writing, can't see or read well, can't get help in filling them out, please let me know.

The second page of this packet is a release of information to send to your doctors/hospitals if needed. If possible, I would like you to try to get copies of your labs, EKGs, echocardiograms, x-ray reports, hospitalizations etc. for the last year or two or that are relevant to your history. Please fill out the release and send it to your doctors or hospitals to get your recent records. *Please* do *not send this release of information form back to me.*

The rest of the packet should be filled out and either faxed back to me at 248-481-9605 or mailed back to me or brought to my office at 3535 West 13 Mile Rd.- Suite 504, Royal Oak MI 48073 or 4000 Highland Rd- Suite 100, Waterford MI 48328.

As soon as I receive your information back, I will get you set up for an appointment. The sooner you get the information back to me, the sooner I can set up your appointment. If you feel your situation is urgent, you can call me or bring it to my office and I will get you in to see me right away if appropriate.

I typically see patients in my Beaumont office on Wednesday and Waterford office on Friday.

Thanks. I look forward to meeting you. Please call me if you have any questions at 248-551-0066.

Jim Heinsimer M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

to

James A. Heinsimer, MD
Specializing in Cardiovascular Diseases
3535 W. 13 Mile Rd - Suite 504
Royal Oak, MI 48073
Phone: 248- 551-0066

Fax: 248-481-9605

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient name:_____

Social Security #: ____-____-_____

Date of Birth: _____

Information requested from: _____

Information requested: *Recent (last 2 years) labs, Discharge summaries, EKGs, Xray reports, echocardiograms, consults, stress tests, catheterization data, typed reports*

_____

_____

_____

The purpose of the use or disclosure of this information is for continuity of care. The health plan or healthcare provider will not receive financial or in-kind compensation in exchange for disclosing the health information described above nor will Dr. Heinsimer use this information other than for continuity of care.

I understand that the payment for my healthcare will not be affected if I do not sign this form. I understand that I may see and copy the information described on this form if I ask for it, and that I may have a copy of this form after I sign it. I understand that this authorization will expire 1(one) year after I sign it. I understand that I may revoke this authorization at any time by notifying Dr. Heinsimer in writing, but if I do it will not have any affect on any actions taken before the receipt of a revocation.

_____ _____

Signature of patient or patient's representative ***Date***

Printed name of patient's representative: _____

Relationship to the patient: _____

New patient History Form- (please print and fill out completely) ***Today's Date:_____***

Name:_____
Social Security number: _____-_____-_____

Work phone number: (____)____ - _____
Extension: _____
Home Phone number: (____)_____-_____
Fax number: (_____) _____ - _____
Cell phone number: (_____) ____ - _____
Home Address:
_____

_____

E-Mail address:_____

Date of Birth :____/____/_____

Insurance:(primary):_____
_____
Acc# Contract Plan Group #
_____
Name listed on card
Insurance: (secondary): _____
_____
Acc# Contract Plan Group #
_____
Name listed on card
(Please attach xerox copy of insurance cards if possible)

Medications (including over the counter, vitamins,herbals)

Name of drug, vitamin or herbal	Dose	How many times/day	Reason for drug	Date drug started

Pharmacy name: _____

Pharmacy phone: (____) _____-_____

(prescription insurance pays for part of each prescription minus copay)

Do you drink alcohol at all? _____
If you don't drink now, did you in the past?____
If you don't drink now, when did you stop?____

If you drink alcohol currently:
How many 4 oz glasses of wine/week? _____
How many 12 oz beers/week? _____
How many 1 oz shots of liquor/week?_____
Were you ever a problem drinker? _____

If you don't smoke now, did you in the past? _____
If you don't smoke now, at what age did you start?____
If you don't smoke now, at what age did you stop?____
If you were a cigarette smoker in the past, how many packs/day did you smoke on average? _____

If you currently smoke or use tobacco now:
How many packs/day of cigarettes? _____
How many cigars/day? _____
How much smokeless tobacco/day?_____
How many pipes/day? _____

At what age did you start?_____
If you were heavier smoker in the past, how many packs/day did you smoke on average?__ _____
Have you ever tried to quit? _____
If yes, how?_____

Do you currently use street drugs, marijuana, or abuse prescription drugs? _____

How would you describe your recent stress level?
Low ___ average___ high ___ very high_____

How much formal exercise (beyond normal working around the house, job, etc do you do)?
None _____ 1-3 hours/week___
3-5 hrs/wk____ 5-7hrs/wk_____ > 7hrs/wk___
Please describe formal exercise activity: _____
_____
Do you take in any caffeine at all? _____
If yes:
How many 8 oz.cups of regular coffee/day? ___
How many 12 oz caffeinated pop/day? _____
How many cups of caffeinated tea/day?_____
How much chocolate or cocoa/day?_____
Do you use decongestants or stimulants? ____

Current weight? _____ pounds

Weight 10 years ago? _____ pounds
Your current height : _____ inches

Special diet?_____
Salt restriction? _____
Sugar or calorie control? _____
Have you ever been diagnosed with diabetes? _____ If yes, since when? _____

Your employer: _____

Job description: _____

Family History (parents, sibs, children)

-use reverse side if needed for additional family members or diseases that run in your family

Relation	First Name	Birthday (if alive)	Age at Death	Illnesses
Father				
Mother				
brother				
Brother				
Brother				
Sister				
Sister				
Sister				
son				
son				
daughter				
daughter				
Spouse				

Other Doctors

Name	Specialty	Phone
		( ) -
		( ) -
		( ) -
		( ) -

Medical problems

Problem, disease, hospitalization	Date of onset

Surgeries/Operations-Accidents/Fractures

Surgery, accident, fracture	Date

Allergies

Allergic to:	Type of Reaction

Health Maintenance (Prevention)

	Date
Last colonoscopy?	
Durable power of attorney for health care?	
Last Bone density test?	
Last Flu (influenza) shot?	
Last Pneumovax (pneumonia) shot?	
(Females) Last pelvic exam/pap?	
(Females) Last mammogram?	
(Males) Last Rectal exam/PSA test?	

GENERAL HEALTH (Please **circle** any recurrent and significant problems not covered above and give details in space provided- also please note approximate start of problem)

Head, eye, ear, nose, throat or neck problems: (such as glaucoma, cataracts, sudden reversible loss of vision, hearing loss, ringing of the ears, nosebleeds, trouble with smell, swollen lymph glands, chronic oral sores or bleeding, goiter, blockages of the arteries of the neck?)

_____

Chest problems (such as cough, coughing up blood, palpitations, heart murmur, fainting spells, asthma, wheezing, trouble sleeping flat in bed, sleep apnea, shortness of breath, chest tightness or pain, history of emphysema, tuberculosis, lung cancer etc:?)

_____

Gastrointestinal or abdominal problems (such as ulcers, blood in the stools, constipation, diarrhea, excess gas, abdominal pain, colitis, liver problems, or pancreas problems?)

_____

Kidney, bladder or sexual problems (such as urinary infections, blood in the urine, trouble starting or stopping the urine stream, incontinence, frequent urination, kidney stones, venereal disease, erectile dysfunction, loss of libido?)

_____

Skin problems (such as cancers, acne, psoriasis, nail problems?)

_____

Psychiatric or emotional problems (such as depression, anxiety, suicide attempts or thoughts?)

_____

Arthritis, Circulation or Muscle problems (such as gout, cramping of legs when you walk, back pain, sciatica, muscle weakness?

_____

Neurologic problems (such as severe or recurrent headache, seizure, stroke?)

_____

Blood disorder (such anemia, easy bruising, or bleeding or clotting problems?)

_____

Hormone problems (such as diabetes, low thyroid, high thyroid or hot flashes, osteoporosis?)

_____

Notice of Privacy Practices - James A. Heinsimer, MD

I, _____, acknowledge that I have been made aware of the Notice of Privacy Practices dated 8/13/02 posted in the office of Dr. James Heinsimer, 3535 W. 13 Mile Rd, Suite 504, Royal Oak, MI 47073, phone: 248-551-0066, fax: 248 481-9605.

I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between Dr. Heinsimer and myself or others.

Signature

Date

Key patient contact numbers

In the event of an emergency, please indicate who should be contacted. Please give as many telephone numbers as possible for a given individual including work, home, cell number, pager etc.

Emergency contact 1: _____
home phone number: (___)_____
cell phone number: (___)_____
work phone number (___)_____
relationship to you: _____

Emergency contact 2: _____
home phone number: (___)_____
cell phone number: (___)_____
work phone number (___)_____
relationship to you: _____

Emergency contact 3: _____
home phone number: (___)_____
cell phone number: (___)_____
work phone number (___)_____
relationship to you: _____

Is emergency contact 1 also your next of kin legally?: ___ yes ___no
If the answer is "no", who is legally responsible for speaking for you in medical situations if you cannot speak for yourself? (name and address)

_____

Next of kin contact (if not listed above):
home phone number: (___)_____
cell phone number: (___)_____
work phone number (___)_____
relationship to you: _____

Have you completed a durable Medical Power of Attorney Form for Health Care? ___yes ___no

Chest Discomfort Questionnaire

Name _____ Today's Date:_____

1 . Is your chest discomfort always the same (same location, same feeling, same things bring it on?) Yes or No

If there is more than one different type of chest discomfort, please go directly to question 14

2. Is your chest discomfort brought on by exercise and/or activities? Yes or No
If yes, by what activities? _____

3. Is your chest discomfort brought on or made worse by: a) food or drink? Yes or No
b) changing in position? Yes or No
c) taking a deep breath? Yes or No
If yes, describe:_____

4. How do you make your chest discomfort go away?_____

5. Have you ever taken antacids for your chest discomfort? Yes or No
If yes, did it help? Yes or No
Do you have a history of esophageal, stomach or bowel disease (such as ulcers)? Yes or No

6. Have you ever taken nitroglycerin for your chest discomfort? Yes or No
If yes, did it help? Yes or No If it helped, how quickly did it help? ____sec ____min ___hrs

7. How would you describe the character of the chest discomfort? (dull, sharp, stabbing, tightness, pressure, weird, other?) Please describe more fully: _____

8. During an episode of chest discomfort: have you ever vomited or been nauseated? Yes or No
had shortness of breath? Yes or No
passed out or nearly passed out? Yes or No
have your heart palpitate (irregular)? Yes or No
If yes to any of the above, please describe:_____

9. On a scale of 1 to 10 (1 is mild, 10 is very severe), how would you rate your typical episode of chest discomfort? _____out of 10

10. What date did you first notice chest discomfort? _____

11. How often have you been having the chest discomfort recently?_____

12. Are the episodes of chest discomfort increasing in frequency? Yes or No

13. How long does a **typical** episode of chest discomfort last?
___seconds ___minutes ___hours ___days

How long did the **shortest** episode of chest discomfort last?
___seconds ___minutes ___hours ___days

How long did the **longest** episode of chest discomfort last?
___seconds ___minutes ___hours ___days

14. When was your most recent episode of chest discomfort?

15. Have you had any EKGs (electrocardiograms) within the last 3 years? Yes or No
If yes, when and where?_____

16. Have you ever had a stress (exercise) test? Yes or No
If yes, when and where?_____

17. Have you ever had a cardiac catheterization (coronary angiography) using dye injected into the blood vessels of the heart? Yes or No
If yes, when and where?_____

18. Have you ever had an echocardiogram (ultrasound sound wave test) of the heart? Yes or No

19. Have you had a chest x-ray within the last 5 years? Yes or No
If yes, when and where?_____

20. If you have more than 1 type of chest pain or discomfort, please fill out the table below:

Chest discomfort <u>Type</u> ***(assign a separate number to each different type of chest discomfort)***	**Brought on <u>by what?</u>** ***(Exercise? Food? Anxiety?, pushing on chest?)***	**Made better <u>by what?</u>** ***(Rest? Nitro? Eating? Movement? Pain med?)***	**<u>Quality:</u>** ***(sharp, burning, tight, pressure, dull, other?) Is there difficulty breathing, palpitations, nausea or vomiting?)***	**Where's the discomfort <u>located?</u>** ***(Left chest, under breastbone, Right chest, jaw, Right arm, Left arm, abdomen?)***	**Severity of <u>discomfort ?</u>** ***(very mild-1-2, mild-3-4, moderate:5-6, severe: 7-10)***	**How long does the discomfort <u>last?</u>** ***(seconds, minutes, hours, days)- shortest?, longest?***
Chest discomfort #1						
Chest discomfort #2						
Chest discomfort #3						
Chest discomfort #4						

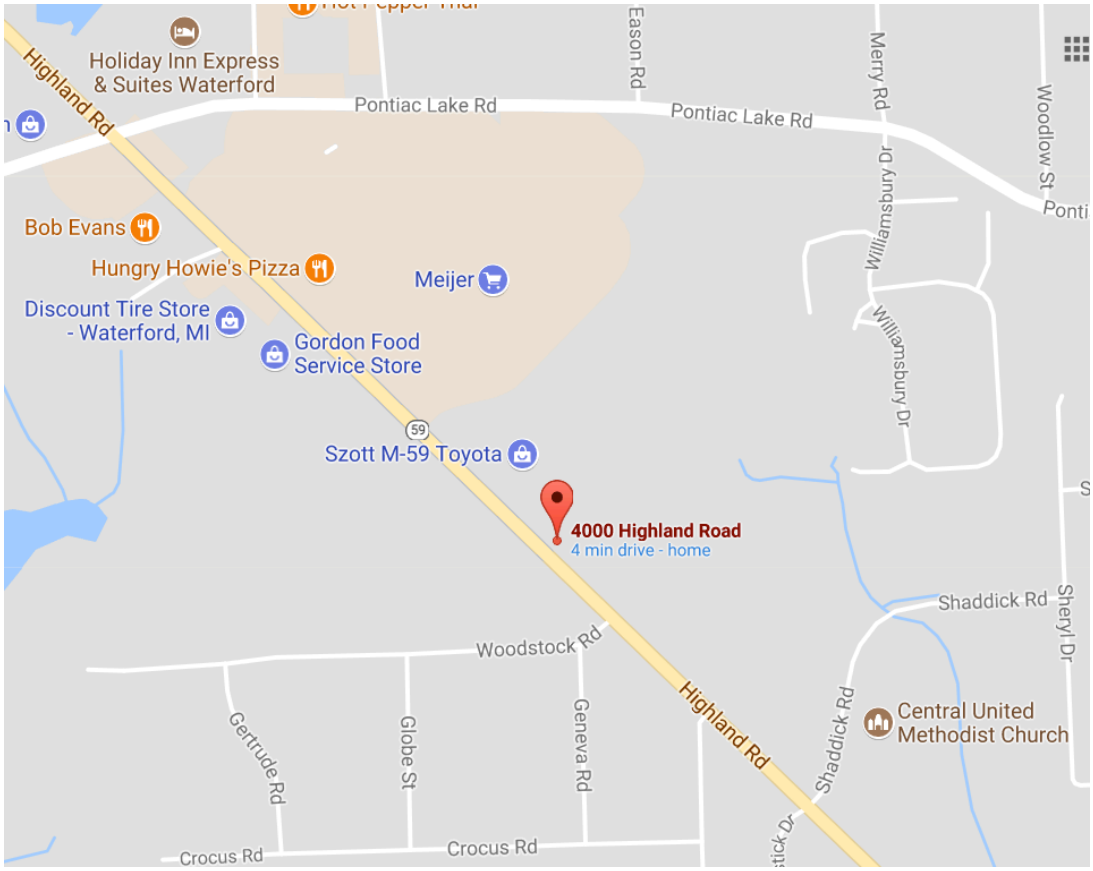
Add any other comments that you think may be helpful: _____
_____
_____
_____
_____

Waterford Office Address Change (Royal Oak Office is Still at 3535 W 13 Mile Road - Suite 504)

** Please be advised that Dr Heinsimer's Waterford office has moved to a new location**
The new Waterford office address is:

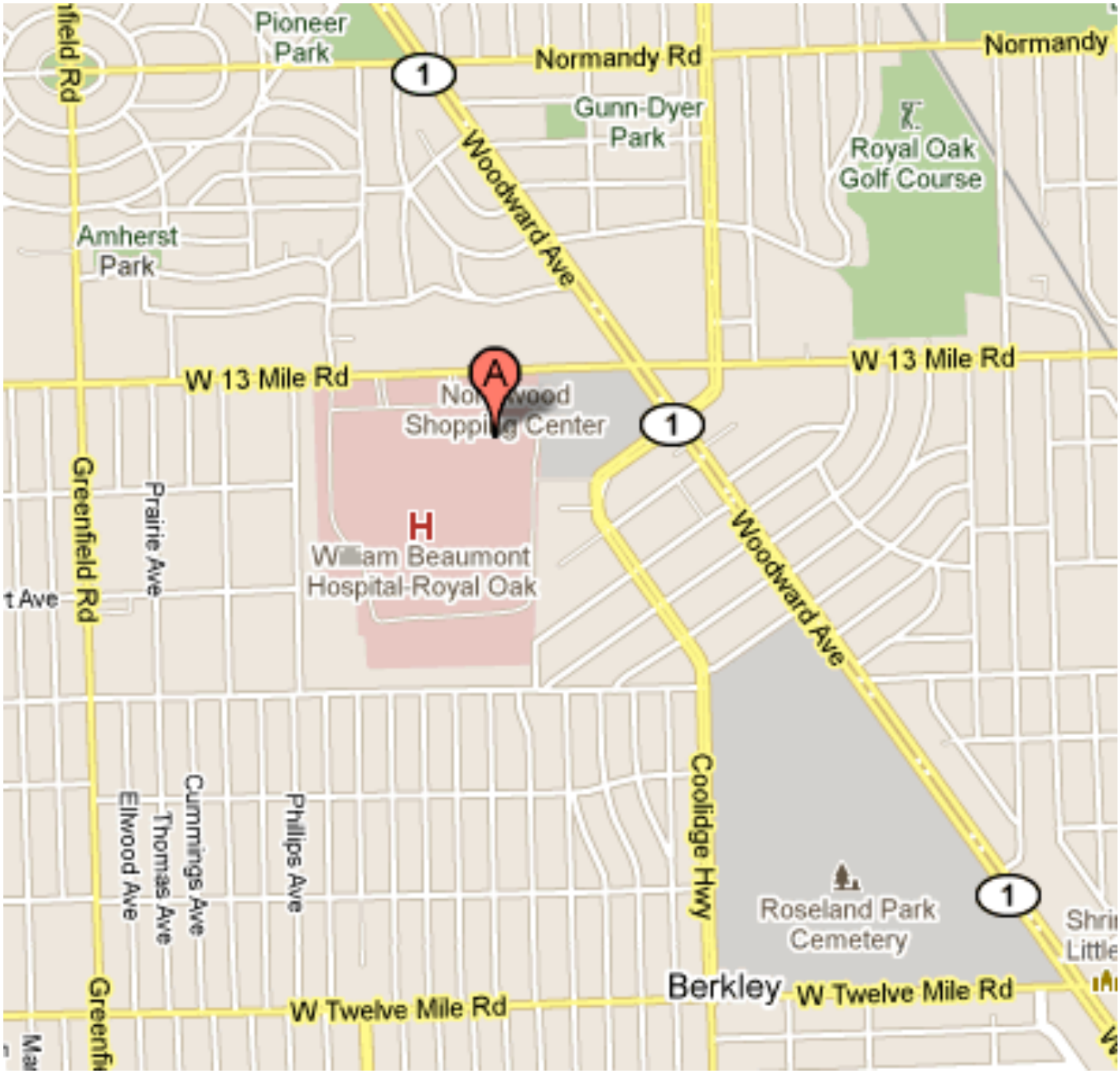
4000 Highland Road (M-59) - Suite 100, Waterford, MI 48328
(the office is at the back of the building - use "North Entrance")

Phone, fax, emergency stays the same for both offices
FYI: The 5220 Highland Office suite was purchased by McLaren Hospital
If you have any questions, please call 248-551-0066



3535 W 13 Mile Road Suite 504 Royal Oak MI 48073

<u>In Beaumont Medical office building across from North parking deck</u>



James A. Heinsimer, M.D.

Board Certified in
Cardiology
Internal Medicine

Phone: 248-551-0066
Fax: 248-481-9605
Emergency: 800-441-7707

Beaumont Medical Office Building
3535 W. Thirteen Mile Road, Suite 209
Royal Oak, Michigan 48073

5220 Highland Road, (M-59) Suite 210
Waterford, Michigan 48327

Beaumont and **St. Joseph Mercy - Oakland** Medical Staff Member

Now Suite 504 not Suite 209 in Royal Oak

Now 4000 Highland Road, (M-59) Suite 100
Waterford, Michigan 48328