

SCOTTSDALE CARDIOVASCULAR CENTER, P.C.
3099 N. CIVIC CENTER PLAZA
SCOTTSDALE, AZ 85251 480-945-3535
www.scottsdalecardiocenter.com

Dear Valued Patient,

We are writing to announce a major change in our medical practice. We are converting our paper charts to an Electronic Medical Records (EMR) system. Our intention is to implement a smooth and seamless transition with minimal impact to you while continuing to provide the highest level of care.

What does this mean for you?

We need your help to ensure the data entered into our new EMR system is as up to date as possible. We understand that some of your data may not have changed but we want to assure new information is entered.

To minimize your time and to ensure scheduled appointment times, it is essential we update your data prior to the next appointment. ** Please note, if we have to update this data at the time of the visit, it will cause a delay. We must input your data and create your chart electronically prior to your physician visit.

Due to the large number of patients in our system, we anticipate some delays with the visit times in addition to the inevitable delays due to emergencies. However, if we all prepare as much as possible for the initial EMR visit, this will help to keep appointments running in a timely manner.

Please arrive at least 15 minutes early for your appointments. If you arrive late for your scheduled appointment, we may need to reschedule the appointment. This is due to the complexity of the scheduling timelines. We must have you here in case additional data needs to be retrieved from other sources.

Another change is in the manner in which prescriptions are given. Please pick up the Open Letter to Patients regarding Electronic (eRX) prescribing changes for details.

We thank you in advance for your patience and understanding during this transition. Our goal is to make the transition to EMR as smooth and seamless as possible for you. We will be doing everything in our power to ensure that all of your personal data is entered quickly and your electronic record brought complete up to date.

Thank you for selecting Scottsdale Cardiovascular Center PC for your Cardiovascular Care!

ALLERGIES: MEDICATION? X-ray CONTRAST?

SURGERIES AND PROCEDURES

Have you had cardiac catheterization? Yes No Date: _____

Facility: _____

Was this intervention? Stent? Balloon? (circle one)

Multiple catheterizations? _____

Have you had vascular surgery? Yes No Date: _____

Facility: _____

Was this bypass graft? Angioplasty? Stent? (circle one)

Have you had heart surgery? Yes No TYPE: _____

Date: _____

Facility: _____

Did you have difficulty during any of these procedures? _____

Other Surgeries:

<i>Type</i>	<i>Date</i>	<i>Facility</i>	<i>Surgeon</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Females only: Have you had a total hysterectomy? Ovaries? at age: _____

Do you take birth control? Yes No

Have you gone through menopause? Yes No In the midst of

Do you take hormone replacements? Yes No Type: _____

PERSONAL HISTORY AND RISK FACTORS

Have you been diagnosed with..... ?

Diabetes	Yes	No	When: _____
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High Cholesterol	Yes	No	When: _____
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High Blood Pressure	Yes	No	When: _____
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Blood flow problem limbs	Yes	No	When & which limb: _____
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Venous or Arterial (circle one)

Heart Valve Disease	Yes	No	When & which valve: _____
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Thyroid Disorder	Yes	No	When: _____
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Bleeding tendencies	Yes	No	When & type: _____
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Lung Disease	Yes	No	When: _____
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Dizziness	Yes	No	What are you doing when occurs? _____
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Stroke	Yes	No	When & which side: _____
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Kidney problems	Yes	No	When & type: _____
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Heart Attack	Yes	No	Age: _____
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Initial Here: _____

Are you currently experiencing any of the following symptoms? (please check all that apply)

Cardiac/Vascular	Chest pain or angina	___	Swelling of feet,ankles,hands	___
	Palpitations	___	Leg pain with walking	___
	Syncope (fainting)	___	Varicose Veins	___
	Clamminess	___	Racing heart beat	___
	Cardiac arrest	___	Waking at night short of breath	___
Constitutional	Recent weight gain	___	Fatigue	___
Respiratory	Chronic or Frequent Cough	___	Spitting up Blood	___
	Shortness of breath on exertion	___	Shortness of breath at rest	___
Gastrointestinal	Loss of appetite	___	Nausea or Vomiting	___
	Blood in stool	___	Abdominal pain	___
Musculoskeletal	Joint pain	___	Muscle weakness or pain	___
Skin/Derm	Rash	___	Skin sores	___
Neurological	Frequent Headaches	___	Lightheaded or Dizzy	___
	Seizures	___	Stroke or TIA	___
	Tremors	___	Memory Loss	___
Psychiatric	Nervousness or anxiety	___	Depression	___
	Difficulty Sleeping	___	Hallucinations	___
Genitourinary	Blood in urine	___	Frequent urination	___
	Painful or burning urination	___		
Hematologic	Anemia	___	Bleeding or Bruising Tendency	___
HEENT	Visual changes	___	Hearing loss	___

YOUR SIGNATURE: _____

PRINTED LEGAL NAME: _____

THANK YOU!

FOR OFFICE USE

_____ ABTRACTOR'S INITIALS

_____ DATE ENTERED