Cardiovascular and Thoracic Surgery
Washington Regional

3276 N. North Hills Blvd
Fayetteville, AR 72703
Office: 479-404-2110
Fax: 479-404-2111

RUSSELL H. WOOD, M.D., F.A.C.S., F.A.C.C., F.C.C.P.
JAMES S. COUNCE, M.D, F.A.C.C., F.C.C.P., F.A.C.C.
ROBERT C. JAGGERS, M.D., F.A.C.C.
CHARLES R. COLE, M.D.

KATHY B. SMITH, A.P.N., D.N.P.
RHAGEN L. PANYIK, P.A.-C
KRISTEN L. MARTINEZ, P.A.-C

Patient Name: _____ **DOB:** _____

EMERGENCY CONTACTS

In order to protect your privacy, Cardiovascular and Thoracic Surgery Clinic asks you to list the family member, friends or any person(s) (***including but not limited to spouses, significant others, and legal representatives***) who can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

1. NAME _____ **RELATIONSHIP** _____ **PHONE** _____

ADDRESS _____

2. NAME _____ **RELATIONSHIP** _____ **PHONE** _____

ADDRESS _____

3. NAME _____ **RELATIONSHIP** _____ **PHONE** _____

ADDRESS _____

SIGNATURE: _____ **DATE** _____
(Patient signature above but parent/guardian signature required if patient is under the age of 18)

PHYSICIAN CARE TEAM

PRIMARY CARE PHYSICIAN NAME: _____ **PHONE** _____

ADDRESS: _____

SECONDARY CARE PHYSICIAN NAME: _____ **SPECIALITY:** _____

ADDRESS & PHONE NUMBER: _____

ADDITIONAL CARE PHYSICIAN NAME: _____ **SPECIALITY:** _____

ADDRESS & PHONE NUMBER:

PHARMACY

NAME: _____ **PHONE** _____

ADDRESS: _____

MAIL-ORDER PHARMACY NAME: _____

MAIL-ORDER PHARMACY ADDRESS: _____

Please bring your medications, or a list of them, to your office visit and ask your doctor to write refills for any medications you anticipate needing.

Patients who have been seen by the doctor at appropriate intervals may call for refills on some prescriptions (antibiotics excluded). You may call your pharmacy 2 - 3 days prior to running out of medication so the pharmacy can fax a refill request to the clinic. Please allow 48 hours for refill requests. Requests received after 2 p.m. will be processed within the next two business days. Refills are done on Monday through Thursday.

Patients who use a mail order pharmacy plan will need to pick up written prescriptions from the clinic and mail them to their providing pharmacy.

SIGNATURE: _____ Date: _____

REVIEW OF SYSTEMS (Please mark all that apply)

PATIENT NAME: _____ **PATIENT DOB: _____**

CONSTITUTIONAL
- Chills
- Fatigue
- Fever
- Recent Weight Gain (___ lbs)
- Recent Weight Loss (___ lbs) intentional
- Recent Weight Loss (___ lbs) unintentional

NEUROLOGICAL
- Balance problems
- Dizziness
- Focal Weakness
- Numbness
- Speech disturbance

HEENT
- Blurry vision
- Double vision
- Vision Loss
- Wears Hearing Aids
- Difficulty Hearing
- Hoarseness
- Difficulty Swallowing
- Swelling of the neck

CARDIOVASCULAR
- Chest Pain
- Chest Pressure/Tightness
- Elevated Blood Pressure
- Shortness of Breath
- Excessive/abnormal sweating
- Jaw Pain
- Palpitations
- PND (waking up short of breath)

RESPIRATORY
- Chronic Cough
- Shortness of Breath
- Daytime Sleepiness
- Coughing up blood
- Wheezing

GASTROINTESTINAL
- Abdominal pain
- Constipation
- Diarrhea
- Dysphagia (difficulty swallowing)
- Loss of appetite
- Nausea
- Vomiting

GENITOURINARY
- Frequent Urination
- Blood in Urine
- Incontinence
- Frequent UTIs

MUSCULOSKELETAL
- Back Pain
- Fibromyalgia
- Joint Swelling
- Muscle spasms

ENDOCRINE
- Cold Intolerance
- Dry Skin
- Heat Intolerance
- Hypoglycemia

HEME/LYMPH
- Anemia
- Easy Bruising

PHYCHIATRIC
- Anxiety
- Depression
- Insomnia
- Memory Loss

DERMATOLOGIC
- Skin rash

PATIENT SIGNATURE: _____ **DATE: _____**