

North Office
2200 Park Bend Dr.
Building 1, Suite 401
Austin, TX 78758
Phone: (512) 807-3160
Fax: (512) 339-7743



Round Rock
7215 Wyoming Springs Dr
Building 1, Suite 100
Round Rock, TX 78681
Phone: (512) 807-3180
Fax: (512) 615-9908

Welcome, and thank you for choosing CST! Please tell us how you heard about us: _____

PATIENT INFORMATION

PATIENT NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE #: _____

SEX: _____ DOB: _____
MARITAL STATUS: _____
SS#: _____
EMAIL ADDRESS: _____

EMPLOYMENT STATUS: Employed Unemployed Retired

Employer: _____

Occupation: _____

REFERRING PHYSICIAN: _____

ADDRESS: _____
PHONE: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____
PHONE: _____

INSURANCE INFORMATION

PRIMARY: _____
INSURED: _____
RELATION: _____ DOB: _____
MEMBER ID: _____ GROUP: _____

SECONDARY: _____
MEMBER ID: _____
GROUP: _____

IN CASE OF EMERGENCY, PLEASE CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE: _____

I understand by signing this form, I acknowledge the Notice of Privacy Practices (NOPP) posted at Reception area of the CST office, and that I am able to request a copy of the NOPP from a CST Associate

Signature

Date

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CONFIDENTIAL HEALTH HISTORY

NAME: _____ DOB: _____

REASON YOU ARE HERE: _____

DESCRIBE THE SENSATION: _____

IF YOU ARE EXPERIENCING CHEST DISCOMFORT:
WHEN DID IT START? _____ WHEN DOES IT OCCUR? _____ HOW LONG DOES IT LAST? _____

PLEASE PROVIDE YOUR PAST MEDICAL HISTORY (INCLUDING SURGERY & HOSPITALIZATIONS):

FAMILY MEDICAL HISTORY (CHECK IF YES)

FATHER:	<input type="checkbox"/> LIVING?	<input type="checkbox"/> HEART DISEASE?	<input type="checkbox"/> STROKE?
MOTHER:	<input type="checkbox"/> LIVING?	<input type="checkbox"/> HEART DISEASE?	<input type="checkbox"/> STROKE?
GRANDPARENTS:	<input type="checkbox"/> LIVING?	<input type="checkbox"/> HEART DISEASE?	<input type="checkbox"/> STROKE?
BROTHER/SISTER:	<input type="checkbox"/> LIVING?	<input type="checkbox"/> HEART DISEASE?	<input type="checkbox"/> STROKE?
AUNT/UNCLE:	<input type="checkbox"/> LIVING?	<input type="checkbox"/> HEART DISEASE?	<input type="checkbox"/> STROKE?
CHILDREN:	<input type="checkbox"/> LIVING?	<input type="checkbox"/> HEART DISEASE?	<input type="checkbox"/> STROKE?

OTHER HEALTH HISTORY (CHECK IF YES)

<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> HEAT/COLD INTOLERANCE
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEPATITIS
<input type="checkbox"/> BLACKOUT	<input type="checkbox"/> INDIGESTION
<input type="checkbox"/> CLAUDICATION	<input type="checkbox"/> LIVER/GALLBLADDER
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> NUMBNESS
<input type="checkbox"/> COUGH	<input type="checkbox"/> PAINFUL URINATION
<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> PHLEBITIS
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> PNEUMONIA
<input type="checkbox"/> EXCESSIVE THIRST	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> EXCESSIVE ANGER	<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> FAINTING	<input type="checkbox"/> SORE THROAT
<input type="checkbox"/> HEAD INJURY	<input type="checkbox"/> URGENCY/HESITANCY
<input type="checkbox"/> HEADACHES	<input type="checkbox"/> VARICOSE VEINS
<input type="checkbox"/> HEARING	<input type="checkbox"/> VISION
<input type="checkbox"/> HEARTBURN	<input type="checkbox"/> WEIGHTGAIN/LOSS

OTHER REASONS FOR VISIT (CHECK IF YES)

<input type="checkbox"/> TREADMILL TEST
<input type="checkbox"/> PALPITAIONS
<input type="checkbox"/> RAPID HEART BEAT
<input type="checkbox"/> POOR CIRCULATION
<input type="checkbox"/> SHORT OF BREATH
<input type="checkbox"/> SWELLING
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> HEART MURMUR
<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> OTHER

PATIENT CARDIAC RISK FACTORS (CHECK IF YES)

<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> CHOLESTEROL
<input type="checkbox"/> SMOKING	<input type="checkbox"/> DIABETES
<input type="checkbox"/> OBESITY	<input type="checkbox"/> FAMILY HISTORY

ALLERGIES (CHECK IF YES)

<input type="checkbox"/> IODINE
<input type="checkbox"/> PENICILLIN
<input type="checkbox"/> SEAFOOD/SHELLFISH

SOCIAL HISTORY (CHECK IF YES)

<input type="checkbox"/> SMOKE	<input type="checkbox"/> AMOUNT PER DAY	<input type="checkbox"/> QUIT	<input type="checkbox"/> DATE	<input type="checkbox"/> DRUGS	<input type="checkbox"/> AMOUNT PER DAY
<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> CAFFEINE	<input type="checkbox"/> AMOUNT PER DAY		<input type="checkbox"/> DIET?	_____