01.A

# DIVISION OF VASCULAR SURGERY

## PATIENT INTAKE FORM – NEW PATIENTS

Date of appointment_____

Your Name_____ DOB_____ Age_____

Who sent you here?_____

Who is your primary care MD? _____ Phone?_____

Do you have a cardiologist? _____

Do you have a nephrologist (kidney doctor)? _____

Any other caregivers we should send results to? _____

What is the best phone number to reach you?_____

May we leave a message regarding health care at this number? **YES** **NO**

What family members can we share information with (name, relationship, phone number)?

_____

**What is the main problem today?_____**

What are your main (active or inactive) medical problems? _____

_____

_____

_____

_____

List any operations you've had, with dates if you know them: _____

_____

_____

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Please circle any of the following health problems you have had or have now:

**High blood pressure**
**High cholesterol**
**Stroke or ministroke**
**Pain in the legs with walking (claudication)**
**Aneurysm**
**Angina/chest pain**
**Heart attack**
**Congestive heart failure**
**Abnormal heart rhythm**
**Pacemaker or AICD**
**Varicose veins/stripping**
**Diabetes**
**Asthma**
**Stomach ulcers**
**Anemia**
**Cataracts**
**Pneumonia**
**Emphysema or COPD**
**Gastric reflux**
**Ulcerative colitis or Crohn's**
**Kidney failure or problems**
**HIV or AIDS**
**Hepatitis**
**Bleeding or clotting problems**
**Thyroid problems**
**Seizure disorder**
**Cancer**
**Sleep disorders**
**Liver problems**
**Prostate problems**

| What medications are you on? | DOSE | Times/day |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

What are your allergies?_____

Risk factors: Do you smoke? **YES** **NO** If yes, packs/day: _____ Year **quit**: _____

Do you drink? **YES** **NO** If yes, drinks per day: _____ per week:_____

Do you use recreational drugs: **YES** **NO** Describe: _____

Do you have COPD? **YES** Are you on oxygen? **YES**

What is/was your occupation? _____ **RETIRED?**

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| | Person | Problems | Cause (date) of death |
|---|---|---|---|
| What problems run in the family? | Father | _____ | _____ |
| | Mother | _____ | _____ |
| | Sibling(s) | _____ | _____ |
| | Aunts/uncles | _____ | _____ |
| | Other? | _____ | _____ |

Please circle any recent or ongoing symptoms that bother you at this point:

| | | | | | |
|---|---|---|---|---|---|
| Constitutional: | **Fever** | **Chills** | **Fatigue** | **Weight loss** | **Weight gain** |
| Eyes: | **Double vision**<br>**Eye injury** | **Blurry vision**<br>**Eye surgery** | **Glaucoma** | **Color blindness** | |
| Head and neck: | **Sinusitis**<br>**Mouth sores** | **Hearing loss**<br>**Voice change** | **Ringing in ears**<br>**Neck swelling** | | |
| Cardiovascular: | **Chest pain** | **High BP** | **Palpitations** | **Leg swelling** | |
| Respiratory: | **Short of breath**<br>**Spitting blood** | **Asthma**<br>**Cold/flu** | **Cough**<br>**Bronchitis** | **Wheezing**<br>**Pneumonia** | |
| Gastrointestinal: | **Poor appetite**<br>**Constipation** | **Nausea**<br>**Blood in stool** | **Vomiting** | **Diarrhea** | |
| Genitourinary: | **Frequent**<br>**UTI** | **Painful urination**<br>**Erectile dysfunction** | **Incontinence** | **Irregular periods** | |
| Musculoskeletal: | **Arthritis** | **Leg swelling** | **Night cramps** | **Spinal stenosis** | |
| Skin: | **Rashes** | **Ulcers** | **Nail changes** | | |
| Neurologic: | **Stroke, TIA** | **Headaches** | **Dizziness** | **Seizures** | **Balance loss** |
| Psychological: | **Depression** | **Memory loss** | **Dementia** | **Anxiety** | |
| Endocrine: | **Diabetes** | **Hyperthyroid** | **Hypothyroid** | **Excessive thirst** | |
| Hematologic: | **Easy bruising** | **Bleeding problem** | **DVT or phlebitis** | | |
| Infection: | **Hepatitis** | | | | |
| Breast: | **Breast lump** | **Nipple discharge** | **Other** | | |

Reviewed (physician): _____ Date _____

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