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** **Eye injury**	**Blurry vision** **Eye surgery**	**Glaucoma**	**Color blindness**	
Head and neck:	**Sinusitis** **Mouth sores**	**Hearing loss** **Voice change**	**Ringing in ears** **Neck swelling**		
Cardiovascular:	**Chest pain**	**High BP**	**Palpitations**	**Leg swelling**	
Respiratory:	**Short of breath** **Spitting blood**	**Asthma** **Cold/flu**	**Cough** **Bronchitis**	**Wheezing** **Pneumonia**	
Gastrointestinal:	**Poor appetite** **Constipation**	**Nausea** **Blood in stool**	**Vomiting**	**Diarrhea**	
Genitourinary:	**Frequent** **UTI**	**Painful urination** **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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