



**DIVISION OF VASCULAR SURGERY
PATIENT INTAKE FORM – ESTABLISHED PATIENTS**

Date of appointment _____

Your Name _____ DOB _____ Age _____

What is the main problem today? _____

Physician contact information: **PLEASE INCLUDE FIRST NAMES IF YOU KNOW THEM:**

Who is your primary care MD? _____

Who is your cardiologist? N/A _____

Who is your nephrologist? N/A _____

At what center do you receive dialysis? _____

Any other doctors we should send info to? _____

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

Circle: Heart Disease Diabetes Hypertension Renal failure Stroke Bleeding problems COPD

Any symptoms you are NOW having, or other things to discuss? _____

Any changes in your health (or recent surgery) since we last saw you? _____

NO OTHER CHANGES SINCE LAST VISIT – no need to fill out anything further unless needed.

Any medication changes since we've seen you last?

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 any recreational drugs? **YES** _____

Please **circle** any recent or ongoing symptoms that bother you NOW:

Constitutional:	Activity change Weight change	Appetite change	Chills	Sweating	Fever
Head and neck:	Congestion Postnasal drip	Dental problems Sinus pressure	Ear pain Sore throat	Hearing loss Tinnitus	Nosebleeds Trouble swallowing
Eyes:	Eye discharge	Eye itching	Eye pain	Eye redness	Visual disturbance
Respiratory:	Chest tightness	Choking	Cough	Short of breath	Wheezing
Cardiovascular:	Chest pain	Leg swelling	Palpitations		
Gastrointestinal:	Abdom swelling Diarrhea	Abdom pain Nausea	Anal bleeding Rectal pain	Blood in stool Vomiting	Constipation
Endocrine:	Cold intolerance	Heat intolerance	Excessive thirst	Excessive appetite	Excessive urination
Genitourinary:	Difficulty urinating	Painful urination	Frequency	Blood in urine	Vaginal problem
Musculoskeletal:	Joint pain	Back pain	Trouble walking	Joint swelling	Neck pain/stiffness
Skin:	Color change	Paleness	Rashes	Wound	
Neurologic:	Dizziness Seizures	Facial changes Speech problems	Headache Loss of conscious	Lightheadedness Tremors	Numbness Weakness
Psychological:	Depression	Memory loss	Dementia	Anxiety	
Hematologic:	Lymph node swelling		Easy bruising or bleeding problem		
Psychiatric:	Agitation	Behavior probs	Confusion	Sleep disturbance	Suicidal thinking

Physician Review: _____ Date _____