01.A

DIVISION OF VASCULAR SURGERY

PATIENT INTAKE FORM – NEW PATIENTS

Date of appointment_____

Your Name_____ DOB_____ Age_____

Who sent you here? _____

What is your 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? _____

Mon-Wed-Fri or **Tues-Thurs-Sat**

Any other doctors we should send info 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 are your main (active or inactive) medical problems? _____

_____

_____

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

_____

_____

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
Emphysema or COPD
Pneumonia
Prostate problems
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

What medications are you on? (or attach list)	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?**

	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**	**Weight loss**	**Malaise/fatigue**	**Sweating**
	Weakness				
Skin:	**Rash**	**Itching**			
Head and neck:	**Headaches**	**Hearing loss**	**Ringing/Tinnitus**	**Ear pain**	**Ear discharge**
	Nosebleeds	**Congestion**	**Stridor**	**Sore throat**	
Eyes:	**Blurred vision**	**Double vision**	**Light sensitive**	**Eye pain**	**Eye discharge**
	Eye redness				
Cardiovascular:	**Chest pain**	**Palpitations**	**Shortness of breath lying down**		**Leg pain**
	Leg swelling				
Respiratory:	**Cough**	**Coughing blood**	**Excess sputum**	**Short of breath**	**Wheezing**
Gastrointestinal:	**Heartburn**	**Nausea**	**Vomiting**	**Abd. Pain**	**Diarrhea**
	Constipation	**Blood in stool**	**Rectal bleeding**		
Genitourinary:	**Painful urination**	**Urgency/Frequency**	**Blood in urine**	**Flank pain**	
Musculoskeletal:	**Muscle pain**	**Neck pain**	**Back pain**	**Joint pain**	**Falls**
Endocrine:	**Easy bruising or bleeding**		**Environmental allergy**	**Excess thirst**	
Neurologic:	**Dizziness**	**Tingling**	**Tremor**	**Sensory changes**	**Speech changes**
	Focal weakness	**Seizures**	**Loss of consciousness**		
Psychological:	**Depression**	**Suicidal ideas**	**Substance abuse**	**Hallucinations**	**Nervous/Anxious**
	Insomnia	**Memory loss**			

Anything else we need to know?