**01.A**



# DIVISION OF VASCULAR SURGERY

**PATIENT INTAKE FORM – NEW PATIENTS**

Date of appointment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_

Physician contact information: **PLEASE INCLUDE FIRST NAMES IF YOU KNOW THEM** (our computers are dumb!):

 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 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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**  |  | **Cataracts**  |
|  **High cholesterol**  |  | **Pneumonia**  |
|  **Stroke or ministroke**  |  | **Emphysema or COPD**  |
|  **Pain in the legs with walking (claudication)**  |  | **Gastric reflux**  |
|  **Aneurysm**  |  | **Ulcerative colitis or Crohn’s**  |
|  **Angina/chest pain**  |  | **Kidney failure or problems**  |
|  **Heart attack**  |  | **HIV or AIDS**  |
|  **Congestive heart failure**  |  | **Hepatitis**  |
|  **Abnormal heart rhythm**  |  | **Bleeding or clotting problems**  |
|  **Pacemaker or AICD**  |  | **Thyroid problems**  |  |
|  **Varicose veins/stripping**  |  | **Seizure disorder**  |  |
|  **Diabetes**  |  | **Cancer**  |  |
|  **Asthma**  |  | **Sleep disorders**  |  |
|  **Stomach ulcers**  |  | **Liver problems**  |  |
|  **Anemia**    |  | **Prostate problems**   |   |
| What medications are you on?   |  | DOSE  | Times/day  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
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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**:**  | **Activity change**  | **Appetite change**  | **Chills**  | **Sweating Fever**  |
|  | **Weight change**  |  |  |  |
| Head and neck**:**  | **Congestion**  | **Dental problems**  | **Ear pain**  | **Hearing loss Nosebleeds**  |
|   | **Postnasal drip**  | **Sinus pressure**  | **Sore throat**  | **Tinnitus 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**  | **Abdom pain**  | **Anal bleeding**  | **Blood in stool Constipation**  |
|  | **Diarrhea**  | **Nausea**  | **Rectal pain**  | **Vomiting**  |
|  |  |  |  |  |
| 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 changes Paleness**  | **Rashes Wound**  |
|  Allergy:  | **Environmental allergy Food allergy**  | **Immunocompromized**  |
| Neurologic**:**  | **Dizziness Facial changes**  | **Headache Lightheadedness Numbness**  |
|  | **Seizures Speech problems**  | **Loss of conscious Tremors 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_