**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_