

# SJRA Vascular Care Center New Patient Form

In an effort to serve you better, we request that you provide us with the following information. we need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name: _____ First: _____ Age: _____ Sex: _____					Doctor Notes please do not write in this area	
Presenting Problem or Proposed Surgery:						
ILLNESS/INJURY: Please check if you have ever had:						
Yes	No		Yes	No		
		High blood pressure			Kidney Stones	
		Diabetes			Abdominal bleeding	
		Peptic ulcers			Diverticulosis	
		Heart attack			Thyroid problem	
		Chest pain/tightness			Lung problems/asthma	
		History of heart murmur			Shortness of breath	
		Stroke			Accidents/broken bones (list)	
		Cancer				
		Hepatitis				
		Yellow jaundice				
		Gallstones				
OPERATIONS: List names and dates of all operations you have had • None						
Year	Name of Operation		Type of Anesthetic, if Known		Complications	
Have you ever had a blood transfusion? • Yes • No Date: _____						
List any hospital admissions or medical conditions not list above:						
FEMALES ONLY: Are you pregnant? • Yes • No						
DRUGS: Please list all drugs you take and their dosages. • None						
Drug	Dosage		Drug	Dosage		
ALLERGIES: Please list type and reaction • None						
Name of Drug		Reaction		Name of Drug		Reaction
Do you now use tobacco? • Yes • No Day # Yrs ___ / ___						
Have you ever used tobacco? • Yes • No Yrs Quit _____						
Do you drink alcohol? • Yes • No Day # Yrs ___ / ___						
Have you ever used alcohol? • Yes • No Yrs Quit _____						
Type: _____						
The above information is true and accurate.						
Patient Signature (parent if patient is a minor) _____						