

DATE:  
 PATIENT #:  
 PATIENT NAME:  
 DOB: / AGE:  
 SEX:

**Vascular Care Center New Patient History & Physical**

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

**Your Physicians:**

Primary/Family: \_\_\_\_\_ Radiation Therapy: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Gynecology/Urology: \_\_\_\_\_

Other: \_\_\_\_\_

**How did you hear about us:**

Physician (name) \_\_\_\_\_  
 Specialist     Family/Friend     Radio     Newspaper/Magazine     TV     Internet     Other

**History of Present Illness: (reason for your visit today)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History: (check any that apply)**

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Substance abuse
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	

**Current Treatments: (check all that apply and indicate dates)**

<input type="checkbox"/>	Chemo therapy	<input type="checkbox"/>	Pain Management	<input type="checkbox"/>	
<input type="checkbox"/>	HemoDialysis	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	
<input type="checkbox"/>	Peritoneal Dialysis	<input type="checkbox"/>	Other:	<input type="checkbox"/>	

**Past Surgical History: (indicate dates please)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT #:  
 PATIENT NAME:

Current Medications and dose (including non prescription and vitamins):

---



---



---



---

Drug Allergies:

No Known Drug Allergies     Penicillin     Sulfa

(other) \_\_\_\_\_

---



---

Social History:

Smoking

Cigarettes / Cigars / or Pipe (circle please)

How many packs per week? \_\_\_\_\_

How many years? \_\_\_\_\_

If you stopped smoking when did you stop? \_\_\_\_\_

Alcohol

Wine / Beer / Liquor (circle please)

How much? \_\_\_\_\_

How often? \_\_\_\_\_

Family History:

Deceased

	M / F	Age	Illnesses / Health (indicate type of cancer if present)	Age (at death)	Cause
Father					
Mother					
Siblings					
Siblings					
Siblings					
Siblings					
Siblings					
Brother / Sister					
Child					
Child					
Child					
Child					
Child					
Child					
Spouse					

PATIENT # :  
 PATIENT NAME :

**REVIEW OF SYSTEMS**

Do you now or in the recent past have problems related to the following systems?

<b>Constitutional</b>	Yes	No	<b>Genitourinary</b>	Yes	No
Fever			Blood in urine		
Chills			Painful urination		
Night Sweats			Frequent urination		
Weight Loss			Urinary retention		
Excessive Fatigue			Other		
Other			<b>Musculoskeletal</b>		
<b>Head/Eyes/Ears/Nose/Throat</b>			Back pain		
Blurred Vision			Joint pain		
Double Vision			Joint deformities		
Pain			Neck pain		
Teaming			Other		
Ear Infections			<b>Integumentary</b>		
Sore Throat			Chronic dry skin		
Sinus Problems			Hives		
Hearing Loss			Persistent itching		
Difficulty Swallowing			Rash		
Change in Voice			Unhealed sores		
Other:			Other		
<b>Neurologic</b>			<b>Peripheral Vascular</b>		
Tremors					
Dizziness / Fainting			Numbness		
Numbness/Tingling			Swelling		
Headache			Tingling		
Seizures			Weakness		
Weakness			<b>Endocrine</b>		
Other			Excessive thirst		
<b>Cardiovascular</b>			High blood sugar / diabetes		
Chest Pain			Too hot / cold		
Edema / Swelling			Other		
High Blood Pressure			<b>Allergic / Immunologic</b>		
Heart Murmur			Seasonal allergies		
Irregular heart rhythm			Food allergies		
Palpitations			Animal allergies		
Other			Other		
<b>Respiratory</b>			<b>Hematologic / Lymphatic</b>		
Frequent colds			Bleeding / clotting problems		
Bloody sputum			Excessive bruising		
Shortness of breath			Swollen glands		
Wheezing			Lymph nodes removed		
<b>Gastrointestinal</b>			Other		
Abdominal pain			<b>Psychological / Spiritual</b>		
Bloody stools			Anxiety Disorder		
Chronic diarrhea			Depression		
Frequent Indigestion			Do you have a support system?		
Nausea / Vomiting			Are you generally satisfied with your life?		
Other			Other		

**Signature** \_\_\_\_\_

**(date)** \_\_\_\_\_