Patient Information

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Date of Birth (MM/DD/YY):			
Social Security #:	Sex: Male ☐	Female ☐	
Home Phone #:	Mobile Phone #:		
Email Address:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
In Case of Emergency Please Contact: Name:	Relationship to Patient: Phone #:		

Employer Information

Employer Name:	Employment Status: ☐ Full Time ☐ Student	☐ Part Time ☐ Retired	
Address:	City:	State:	Zip Code:
Work Phone Number:	Patient Occupation:		

Insurance Information (Please provide card to Front Office)

Primary Insurance Plan Name:		
Insured Name:	Date of Birth:	Social Security #:
Insured Employer:	Employer Phone Number:	
Secondary Insurance Plan Name:		
Insured Name:	Date of Birth:	Social Security Number:
Insured Employer:	Employer Phone Number:	

Physician Information

Name of Referring Physician:	Name of Primary Physician:			
How did you find our practice? (circle all that apply)	Website/Internet	Newspaper	TV	Referral

Do you have a Preferred Pharmacy? ☐ Yes ☐ No If yes, please provide the following information:

Name of Pharmacy:	Phone Number:	
City:	State:	Zip Code:

TEXAN VEIN & VASCULAR

Vascular Surgery Clinic

Name: _____ Date: _____

Date of Birth: _____ Height: _____ Weight: _____

MEDICATIONS (Prescription, Over the counter and Vitamins)

MEDICATION	DOSE	FREQUENCY

MEDICATION ALLERGY NONE ☐

NAME OF MEDICATION	REACTION
NAME OF FOOD ALLERGY	REACTION

Vascular Surgery Clinic

MEDICAL HISTORY

Please circle "YES" or "NO" to any past or current medical conditions

YES	NO	Atrial Fibrillation / Arrhythmia
YES	NO	Coronary Arterial Disease
YES	NO	Heart Failure
YES	NO	Dementia
YES	NO	Seizure Disorder
YES	NO	Diabetes Mellitus Type 2
YES	NO	Asthma
YES	NO	Chronic Obstructive Pulmonary Disease/Emphysema
YES	NO	Bleeding Disorder
YES	NO	Anemia
YES	NO	Deep Vein Thrombosis
YES	NO	Pulmonary Embolism
YES	NO	MRSA Hx
YES	NO	High Cholesterol / Hyperlipidemia
YES	NO	Myocardial Infarction / Heart Attack
YES	NO	Depression
YES	NO	Drug Abuse
YES	NO	Hepatitis C
YES	NO	Peptic Ulcer Disorder
YES	NO	Chronic Kidney Disease / End Stage Renal Disease
YES	NO	Stroke / TIA
YES	NO	Temporary Blindness
YES	NO	Speech Difficulty
YES	NO	Hypertension
YES	NO	Liver Cirrhosis
YES	NO	Hypothyroid
YES	NO	Obesity
YES	NO	Obstructive Sleep Apnea

Vascular Surgery Clinic

SURGICAL HISTORY

		DATE	
YES	NO		Appendectomy
YES	NO		C-Section
YES	NO		CABG (Coronary Bypass Graft)
YES	NO		Cholecystectomy
YES	NO		Hysterectomy
YES	NO		PTCA Hx (Coronary Angioplasty)
YES	NO		Angioplasty / Leg Stent
			Other

FAMILY HISTORY

Relationship	Heart Disease	Stroke	Aneurysm	Other Vascular Problems (Please Specify)	Age of Occurrence
Mother					
Father					
Sister					
Brother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Vascular Surgery Clinic

SOCIAL HISTORY

YES	NO	NEVER	
			Do you smoke?
			Number of years
			Packs per day
	YES	NO	Interested in quitting?
			How long you smoked before quitting?
			Number of years
			Packs per day

YES	NO	NEVER	
			Do you consume alcohol?
DAILY	WEEKLY	MONTHLY	How often?
WINE	BEER	OTHER	Which alcoholic beverage?
	YES	NO	Drug abuse?

LEARNING PREFERENCE

What is your learning preference? (Circle all that applies)

LISTENING READING DEMOSTRATION PICTURES/VIDEOS

OTHER (Please Specify): _____

FALL RISK

Have you fallen in the last 30 days?
(Please circle one)

YES	NO

Vascular Surgery Clinic

REVIEW OF SYSTEMS

Are you currently having problems with any of the following? (Y=YES, N=NO)

Constitutional Symptoms:
Y N Fever
Y N Chills
Y N Weight Gain (lbs.)
Y N Weight Loss (lbs.)
Y N Decreased Appetite

Eye Symptoms:
Y N Change in Vision
Y N Eye Pain
Y N Eye Irritation

Ear, Nose, and Throat:
Y N Decreased Hearing
Y N Vertigo
Y N Ringing in the Ears
Y N Nose/Sinus Problems
Y N Nose Bleeds
Y N Sore Throat
Y N Difficulty Speaking
Y N Bleeding Gums
Y N Teeth Abnormalities

Cardiovascular Symptoms:
Y N Chest Pain on Exertion
Y N Arm Pain on Exertion
Y N Shortness of Breath
Y N Heart Palpitations
Y N Heart Murmurs
Y N Calf or Jaw Pain
Y N Ankle Swelling

Respiratory Symptoms:
Y N Cough
Y N Wheezing
Y N Shortness of Breath

Gastrointestinal Symptoms:
Y N Nausea
Y N Vomiting
Y N Vomiting Blood
Y N Abdominal Pain
Y N Change in Appetite
Y N Heartburn
Y N Black or Tarry Stool

Musculoskeletal Symptoms:
Y N Muscle Aches
Y N Muscle Weakness
Y N Joint Pain
Y N Back Pain
Y N Swelling in Arms/Legs
Y N Difficulty Walking

Integumentary Symptoms:
Y N Dry Skin
Y N Jaundice
Y N Rashes
Y N Discoloration
Y N Growth/Lesions
Y N Ulcers

Allergic/Immunologic:
Y N Runny Nose
Y N Sinus Pressure
Y N Itching
Y N Hives
Y N Frequent Sneezing

Endocrine Symptoms:
Y N Fatigue
Y N Cold Intolerance
Y N Hair Loss
Y N Increased Hair Growth
Y N Irregular Menstrual
Y N Increased Thirst

Hematologic/ Lymphatic:
Y N Swollen Glands
Y N Bruising
Y N Excessive Bleeding

Neurologic Symptoms:
Y N Loss of Consciousness
Y N Slurred Speech
Y N Weakness
Y N Numbness
Y N Headaches
Y N Memory Lapse
Y N Loss of Balance/Falls
Y N Restless Legs

REASON FOR VISIT TODAY (PLEASE SPECIFY)

_____

_____

_____

_____

_____

✖ _____

Client's Signature Date