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LAWNWOOD SURGICAL SPECIALISTS

A Specialists' Practice

VASCULAR SURGERY

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Phone: (772) 595-5302
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Date of appointment_____

Your Name_____ DOB_____ Age_____ Gender _____

Physician contact information:

Who is your primary care doctor? N/A _____
Who is your cardiologist? N/A _____
Who is your nephrologist? N/A _____
Where do you get dialysis? N/A _____
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 medications are you on?	DOSE	Times/day

Which pharmacy do you get your prescriptions filled?
Pharmacy Name _____ Phone Number _____

Do you have a drug allergy? **YES** **NO**
If **YES**, which drugs?

_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

What is the main problem today?

_____

What are your main (active or inactive) medical problems?

_____

_____

_____

_____

Please list any surgical procedures or implants you have had: Year:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please circle any of the following health problems you have had or have now:

High blood pressure
High cholesterol
Abnormal heart rhythm
Heart attack
Congestive heart failure
Diabetes
Stroke or mini stroke
Pneumonia
Emphysema or COPD
Pain in the legs while walking (claudication)
Gastric reflux
DAneurysm
Ulcerative colitis or Crohn's
Angina/chest pain
HIV or AIDS
Hepatitis
Bleeding or clotting problems
Pacemaker or AICD
Varicose veins/stripping
Cancer
Asthma Sleep disorders
Stomach ulcers Kidney failure or probl
Anemia Prostate problems

Risk factors:

Do you smoke? **YES NO** If yes, packs/day: _____ Year **quit:** _____

Have you ever tried to stop smoking? **YES NO**

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 NO** Are you on oxygen? **YES NO**

Vaccines:

Have you had a Flu shot? **YES NO**

Have you had a Pneumonia shot? **YES NO**

What is/was your occupation? _____ **RETIRED?**

Functional activities: Please indicate the highest level of activities you are able to perform.

1.Dressing without having to stop [2 METS] _____
2.Walking at a leisure pace [3 METS] _____
3.Taking a shower or bowling [4 METS] _____
4.Gardening or walking up stairs [5-6 METS] _____
5.Participating in recreational sports [7-10 METS] _____

New patient intake revised 08-19-2015

	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:	Fever	Chills	Fatigue	Weight loss/gain
Eyes:	Double vision Eye injury	Blurry vision Eye surgery	Glaucoma	Color blindness
Head and neck:	Sinusitis Mouth sores	Hearing loss Voice change	Ringing in ears	Neck swelling
Cardiovascular:	Chest pain	High BP	Palpitations	Leg swelling
Respiratory:	Short of breath Spitting blood	Asthma Cold/flu	Cough Bronchitis	Wheezing Pneumonia
Gastrointestinal:	Poor appetite Constipation	Nausea Blood in stool	Vomiting	Diarrhea
Genitourinary:	Frequent UTI Erectile dysfunction	Painful urination	Incontinence	Irregular periods
Musculoskeletal:	Arthritis	Leg swelling	Night cramps	Spinal stenosis
Skin:	Rashes	Ulcers	Nail changes	
Neurologic:	Stroke, TIA Poor balance	Headaches	Dizziness	Seizures
Psychological:	Depression	Memory loss	Dementia	Anxiety
Endocrine:	Diabetes	Hyperthyroid	Hypothyroid	Excessive thirst
Hematologic:	Easy bruising	Bleeding problem	DVT or phlebitis	
Infection:	Hepatitis	Urinary tract (UTI)	Wound	
Implants:	Heart	Joints	Grafts	
Breast:	Breast lump	Nipple discharge	Other: _____	
Others:	_____			

Physician review: _____ Date _____