New Patient Questionnaire

VASCULAR INTERVENTIONAL SPECIALISTS

CORA

Patient Name ______________________ Age ________ DOB ____________ Today's Date ____________

Evaluating Physician ______________________ Referring MD ____________ Phone ____________

Reason for today's visit? ______________________________

When did your symptoms or problem occur? ______________________________

What treatments/test have you had for your current symptoms or problem? ______________________________

____

PAST MEDICAL HISTORY (CHECK ALL CURRENT OR PREVIOUS MEDICAL CONDITIONS THAT APPLY)

- ○ Asthma
- ○ Depression
- ○ High Cholesterol
- ○ Mental Illness
- ○ Bleeding Problems
- ○ Diabetes
- ○ HIV
- ○ Seizures
- ○ Blood Clots
- ○ Heart Disease
- ○ Kidney Disease
- ○ Stroke
- ○ Cancer
- ○ Hepatitis
- ○ Liver Disease
- ○ Ulcer
- ○ COPD
- ○ High Blood Pressure
- ○ Lung Disease
- ○ Other: ____________

PAST SURGICAL HISTORY (CHECK LIST ANY PREVIOUS SURGICAL PROCEDURES AND THE DATE OF SURGERY

- ○ Tonsillectomy ____________
- ○ Arthroscopy ____________
- ○ Spine ____________
- ○ Gallbladder ____________
- ○ Appendectomy ____________
- ○ Hernia Repair ____________
- ○ Other: ____________

MEDICATIONS (PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER

#	NAME OF MEDICATION	DOSE	HOW OFTEN TAKEN?
1.			
2.			
3.			
4.			
5.			

ALLERGIES

1. List medicine allergies and reactions: ______________________________
2. Have you ever had x-ray contrast? If so, please explain. ______________________________
3. Do you tolerate Advil or Motrin? _______ Can you take relaxation medication (Valium/Morphine)? ______________
4. Have you had difficulty with sedation in the past? If so please explain. ______________________________

FAMILY HISTORY

FAMILY MEMBER	ALIVE	DECEASED	AGE	CURENT/PAST MEDICAL CONDITIONS
Mother	◯	◯	________	______________________________
Father	◯	◯	________	______________________________
Sister/Brother	◯	◯	________	______________________________
Sister/Brother	◯	◯	________	______________________________
Sister/Brother	◯	◯	________	______________________________
Sister/Brother	◯	◯	________	______________________________
Children	◯	◯	________	______________________________

SOCIAL HISTORY

Occupation ______________________________

Highest level of education completed:

◯ Grammar ◯ High School ◯ College ◯ Post Graduate

Marital Status:

◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced

Alcohol use:

◯ Yes, daily ◯ ≥ 1 time per week ◯ ≥ 1 time per month

◯ No, I quit ____ years ago, I used to drink ____ drinks per week.

◯ No, I don't drink alcoholic beverages.

Currently working? ______________________________

Are you on?

◯ Social Security ◯ Disability ◯ Workers Compensation

Tobacco use:

◯ Yes, I've used ________ packs/per day for ________ years.

◯ No, I quit ____ years ago, I used ____ packs/per day for ____ years.

◯ No, I have never used tobacco.

Recreational Drugs

◯ Yes Please list: ______________________________ ◯ No

REVIEW OF SYSTEMS (PLEASE CIRCLE ANY PROBLEMS OR SYMPTOMS YOU HAVE HAD OR CURRENTLY HAVE.)

GENERAL
Recent illness, fever, chills, night sweats, weight loss/gain.

SKIN
Bruising/bleeding disorders, rashes, itching, skin cancer, other disease of the skin

CARDIOVASCULAR
Shortness of breath, palpitations, chest pain, swelling in extremities, murmur, angina.

RESPIRATORY
Chronic cough, wheezing, pain with breathing, productive cough.

GASTROINTESTINAL
Nausea, vomiting, diarrhea, constipation, heartburn, ulcers, blood in stool, jaundice.

GENITOURINARY
Blood in urine, difficulty controlling bowel/bladder, urinary frequency/urgency or burning.

NEUROLOGICAL
Headaches, seizures, tremors, paralysis, loss of consciousness, dizziness.

MUSCULOSKELETAL
Joint pain, tingling, burning, backache, neck ache, fatigue.

PSYCHOLOGICAL
Anxiety, suicidal thoughts, mood swings, constant crying, loss of sleep.

Patient Name ______________________________ **Date** ______________

Patient Signature ______________________________ **Date** ______________

***************************** THIS PAGE TO BE FILLED OUT BY PHYSICIANS OFFICE *******************************

Patient Name ______________________________ **Today's Date** ______________

Physical Exam:

V/S: Temp ________ Resp ________ Pulse ________ B/P (R/L) ________ SAO2% ________ Ht ________ Wt ________lb

IMAGING

PROVIDER NOTES

ASSESSMENT & PLAN

PATIENT INSTRUCTIONS