**Welcome to Lafayette Vein and Vascular Center**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**:

We prefer if you bring all bottles of your medications with you, however we understand this can be difficult for some people. If you are unable to bring the bottles please take the time to fill out the medication table below. All sections need to be filled out completely. This will help us to ensure that whatever information we have obtained prior to your arrival is up to date and there are no errors.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Dose | Doses per day (once, twice, etc.) | Medication | Dose | Doses per day (once, twice, etc.) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Allergies**: List all **medication** allergies and reactions you have had.

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Allergy/Reaction to medication | Medication | Allergy/Reaction to medication |
|  |  |  |  |
|  |  |  |  |

**Medical History**: Place a check next to any conditions you have been diagnosed with previously.

|  |  |
| --- | --- |
| * Abdominal Aortic Aneurysm (AAA) | * Hepatitis A, B, or C |
| * Anemia, low blood count | * Hiatal Hernia |
| * Antibiotic resistant infection (MRSA) | * High cholesterol |
| * Anxiety | * High blood pressure |
| * Arthritis | * HIV/AIDS |
| * Asthma | * Bleeding disorders |
| * Atrial fibrillation or other rhythm problem | * Blood clots/ DVT |
| * Prostate problems | * Cancer, type \_\_\_\_\_\_\_\_\_\_ |
| * Carotid disease | * Chest pain, angina |
| * Chronic bronchitis | * Colitis |
| * Congestive Heart Failure | * Depression |
| * Diabetes, Type ( I or II) \_\_\_\_\_\_\_\_\_\_ | * COPD |
| * Gout | * Heart Attack |
| * Hyperthyroidism | * Hypothyroidism |
| * Kidney disease (failure/insufficiency) | * Liver disease |
| * Pregnancies, how many \_\_\_\_\_\_\_\_\_ | * Pulmonary embolism |
| * Reflux (GERD) | * Stomach Ulcer |
| * Stroke (CVA) or Mini Stroke (TIA) | * TB Exposure |
| * Thoracic Aortic Aneurysm | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Surgical History**: Please list you surgeries/procedures along with the year it was performed.

|  |  |  |  |
| --- | --- | --- | --- |
| Procedure | Year | Procedure | Year |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Family History**: Provide age and diagnosis for family members.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Brother | Brother | Sister | Sister |
| Age if alive |  |  |  |  |  |  |
| Age deceased |  |  |  |  |  |  |
| Aneurysm |  |  |  |  |  |  |
| Cancer, type |  |  |  |  |  |  |
| Heart  Disease |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |

Other family medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History/ Risk factors**: Please circle or check for all the following that apply to you.

Marital Status: Single, Married, Divorced, Widowed Current Smoker: Yes, No # Packs/day \_\_\_\_\_ Quit? What year \_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Retired? Yes, No Alchohol intake: # drinks \_\_\_\_\_/ day/ month/ year. Type: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**: Place a check next to any symptoms that you have had in past 6 months

|  |  |  |  |
| --- | --- | --- | --- |
| **General**   * Normal * Wt loss? Lbs \_\_\_ Since\_\_\_ * Wt Gain? Lbs \_\_\_ * Since\_\_\_ * Fevers * Chills * Night Sweats * Fatigue | **Eyes/ENT**   * Normal * Vision Loss * Hearing Losss * Sore throat * Hoarseness * Sinus Infection * Dizziness | **Neurological**   * Normal * Headaches * Weakness * Confusion * Stroke * Temporary Paralysis * Seizures | **Respiratory**   * Normal * Shortness of breath lying flat * Shortness of breath at rest * Shortness of breath with exercise * Wheezing * Dry Cough * Coughing up blood |
| **Cardiovascular**   * Normal * Irregular heart beat * Racing heart * Chest discomfort/pain * Black out/passing out * Heart murmur * Bilateral leg swelling | **Hematologic**   * Normal * Easy bruising * Blood nose * Swollen lymph nodes * Bleeding problems * Blood clots, vein clots, milk leg | **Endocrine**   * Normal * Hyperthyroidism * Hypothyroidism * Hot Flashes * Heat Intolerance * Cold Intolerance * Excessive Thirst * Excessive Urination | **Psychiatric**   * Normal * Depression * Anxiety * Panic Attacks |
| **Gastrointestinal**   * Normal * Jaundice * liver problem Abdominal pain * Nausea * Vomiting * Blood in stool * Diarrhea * Constipation * Indigestion/reflux Heartburn * Difficult swallowing * Decreased Appetite | **Genitourinary**   * Prostate enlargement * Urinate frequently * Urinary incontinence * Bladder infection * Kidney failure * Blood urine * Impotence * Erectile dysfunction * Post-meopausal | **Musculoskeletal**   * Normal  Arthritis * Back pain * Leg swelling * Arm swelling * Varicose veins * Leg ulcers (sores) * Neck pain * Leg cramp/discomfort * Foot pain at night * Weakness * Extremity pain | **Socioeconomic**   * No concern * Financial burden * Food insecurity * No Shelter * No Primary Care Doctor * No support system * Lack of reliable transportation |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_