Patient Name: ________________________________DOB: __________________________MRN: ___________

BSW VASCULAR SURGERY SPECIALISTS - - - - PATIENT INTAKE FORMS

Please present a current medication/allergy list at check-in

Primary reason for visit today:

____

Medical History: Do YOU have any of the following conditions?

Aneurysm Yes / No
Type:_____________________________
Arthritis Yes / No
Bleeding Disorder Yes / No
Type:_____________________________
Cancer Yes / No
Type:_____________________________
Coronary Artery Disease Yes / No
Myocardial Infarction Yes / No
Hypercholesterolemia Yes / No
Hyperlipidemia Yes / No
Hypertension Yes / No
Diabetes Yes / No
Type:_____________________________
Congestive Heart Failure Yes / No
Defibrillator Yes / No

COPD Yes / No
Emphysema Yes / No
Pulmonary Embolism (PE) Yes / No
Kidney Disorder Yes / No
Dialysis Access Yes / No
Erectile Dysfunction Yes / No
Leg Trauma Yes /No
Deep Vein Thrombosis Yes / No
Stroke / CVA Yes / No
Varicose Veins Yes / No
Hepatitis Yes / No
Type:_________________________________
HIV Yes / No
Tuberculosis (TB) Yes / No
Pacemaker Yes / No

Social History:

Vision Impairment Yes / No
Hearing Impairment Yes / No
Religion Affecting Care Yes / No
History of Domestic Abuse Yes / No
History of tobacco use Never Yes ___________ packs per day Former, quit date _________________
Cigarettes Pipe Cigars Electronic Cigarette
Alcohol Use Never Socially Yes Drinks per day _______________________
Pharmacy:____
Primary/Family Physician ____
Lives with: ____
Children: ________________________________

Family History: Has your immediate family been diagnosed with any of the following conditions?

Aneurysm Yes / No
Type: __________________
Bleeding Disorder Yes / No
Coronary Artery Disease Yes / No
Myocardial Infarction Yes / No
Coronary Artery Bypass Graft Yes / No
Kidney Surgery Yes / No
Deep Vein Thrombosis Yes / No
Varicose Veins Yes / No

Arthritis Yes / No
Asthma Yes / No
Cancer Yes / No
Type: ________________________________
Hyperlipidemia Yes / No
CVA/Stroke Yes/ No
Diabetes Renal Yes / No
Disease Yes /No
Hypertension Yes / No

Surgical History: approximate date

None
Abdominal Surgery _________________________
Gallbladder Surgery _________________________
Hip/Knee Replacement ______________________
Other _________________________

Breast Surgery ____________________________
Cancer Surgery_____________________________
C – Section _______________________________
Hysterectomy _____________________________

Present Medication:

1.______________________________
2._______________________________
3._______________________________
4._______________________________
5._______________________________

Medication Allergies:

Iodine Yes/No
Latex Yes/No
1.__________________________
2.__________________________
3.__________________________

Please initial one of the following:

__________ **I WILL ALLOW** BSW Vascular Surgery Specialists access and may use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

__________ **I WILL NOT ALLOW** BSW Vascular Surgery Specialists access to my prescription medication history.