



Lake Medical Imaging & Vascular Institute

A Clearer Vision

MEDICAL HISTORY FORM

Please complete in advance and bring with you on the day of your appointment.

Patient's Name _____ Who referred you to us? Self or Dr. _____

SS# _____ Who is your primary care doctor? Dr. _____

Why are you coming for a consult? What kind of problem are you having?

What medical problems do you currently have or have you had in the past?

What surgeries have you had, and when were they performed?

Please check off (✓) any problems that you are having now:

General

- Fever
- Chills
- Weight loss

Respiratory

- Cough
- Shortness of breath
- Difficulty breathing on exertion
- Coughing up blood

Extremities

- Pain when walking
- Discoloration
- Pain at rest
- Ulcers
- Swelling of extremities
- Varicose veins

Neurologic/Psychologic

- Headaches
- Weakness
- Speech changes
- Confusion
- Anxiety
- Depression
- Numbness

Cardiac

- Chest pain
- Palpitations
- Leg swelling
- Difficulty sleeping flat

Ears, Nose, Throat

- Visual changes
- Vision loss
- Hearing changes

Urinary

- Difficulty urinating
- Frequent urination
- Painful urination
- Blood in urine

Gastrointestinal

- Nausea and/or vomiting
- Constipation
- Diarrhea
- Bloody stools
- Black tarry stools

Skin

- Bruising
- Rash
- Itching

Other

- Trauma (more)

Please list all Allergies:

What medicines do you presently take?

Social History:

Do you smoke? _____ If yes, how many packs per day? _____

For how many years? _____ When did you quit? _____

How much alcohol do you drink (drinks per week) _____

Marital status: Single _____ Married _____ Divorced _____ Widowed _____

Live alone (circle one): Yes No

Do you exercise? (How many times a week, for how long) _____

Family History (list diseases family member had or died of):

Father: _____

Mother: _____

Sister(s): _____

Brother(s): _____

Prior radiologic studies (x-rays, ultrasound, CT, MRI, Arteriograms, etc.) (Where and when)

How did you learn about Lake Medical Imaging and Vascular Institute?

I was given a choice to see either the Physician Assistant or the Interventional Radiologist. Yes _____ No _____

Patient Signature

Date

Thank you