



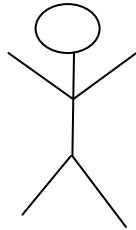
For office use only: B/P: _____ Pulse: _____ Height: _____ Weight: _____ BMI: _____

Physician Notes:

Present Findings:

Imaging Studies:

Physical Exam:



PLEASE COMPLETE IN ADVANCE AND BRING IT WITH YOU ON THE DAY OF YOUR APPOINTMENT.

Patients Name _____ What Doctor is referring you to us? _____

SS# _____ Who is your primary care Physician? _____

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

- Chills
- Weight Loss

Neurological / Psychological

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

Ears, Nose, Throat

- Visual changes
- Vision loss
- Hearing changes

Other

- Trauma _____

Respiratory

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

Cardiac

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

Gastrointestinal

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

Extremities

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

Urinary

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

Skin

- Bruising
- Rash
- Itching

Family History (please list disease that your family member had or has died of):

Father: _____

Mother: _____

Sister(s): _____

Brother(s): _____

**Prior Radiologic studies (x-rays, ultrasound, CT, MRI, arteriograms, etc.)
(When & Where)**

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

Patient Signature

Date