

For office use only: B/P: _ Physician Notes:	Pulse: Height:	Weight:	BMI:			
Present Findings:	Imaging Studies:	Physical I	Physical Exam:			
PLEASE COMPLETE IN ADVAN	CE AND BRING IT WITH YOU O	N THE DAY OF YOUR	R APPOINTMENT.			
Patient Name	Which doct	tor is referring you to us	s?			
SS#	Who is your primary care doctor?					
Reason for consult: What kind of a	a problem are you having?					
What medical problems do you cu What surgeries have you had, and	· · · · · · · · · · · · · · · · · · ·	e past?				
Please check off () any problems t	hat you are having now					
General	Respiratory	E	xtremities			
() Chills	() Cough) Pain when walking			
() Weight Loss	() Short of breath	,) Discoloration			
Neurological / Psycho logic	() Difficulty breath () Coughing up blo) Pain at rest) Ulcers			
() Headaches	() Coughing up bic	-) Swelling of extremities			
() Weakness	Cardiac)Varicose veins			
() Speech Changes	() Chest pain					
() Confusion	() Palpitations		rinary			
() Anxiety	() Leg swelling	-) Difficulty urinating			
() Depression	() Difficulty sleepi	•) Frequent urination			
() Numbness	Costraintestinal	-) Painful urination			
Ears, Nose, Throat	Gastrointestinal () Nausea and/or v) Blood in urine			
() Visual changes	() Constipation	C	kin			
() Vision loss	() Diarrhea) Bruising			
() Hearing changes	() Bloody stools) Rash			
- 0	() Black tarry stool	ls () Itching			
Other						

() Trauma_____

Please list all Drug Allergies:								
Do you have ar	ny allerg	gies to?						
acrylic		acrylic nails		glue products				
Patient Medica To ensure the hi we are as inform	ighest qu	uality care				mplete the follo	wing Medication Li	ist to be assured
Prescriptions								
Brand or Generic		Dose (total mg	<u>(</u>)	How often do you take this Rx?	When do you take it? (time of day. With or without meals?)	Who is the prescribing Physician?	What is it taken for?	Have you experienced any side effects to this medication? If so please explain
Over-the-cou	nter me	edication	s, he	erbal reme	dies, vitamins			

Social History:			
Do you smoke? If yes	s, how many packs per day?_	For how many years?	_
When did you quit?			
How much alcohol do you dri	nk? (drinks per week)		
Marital status: Single	Married Divorced	l Widowed	
Live alone (circle one) Yes	No		
Do you exercise?	How many times per week	x? For how long?	
Family History (list diseas	e family member had or	died of):	
Father:			
Mother:			
Sister(s):			
Brother(s):			
Prior Radiologic studies (x	x-rays, ultrasound, CT, N	IRI, Arteriograms, etc.)	
(When & Where)			
How did you hear about I	ake Medical Imaging and	d Vascular Institute?	
Patient Signature		Date	