



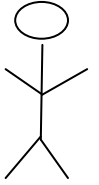
For office use only: B/P: _____ Pulse: _____ Height: _____ Weight: _____ BMI: _____

Physician Notes:

Present Findings:

Imaging Studies:

Physical Exam:



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

Patient Name _____ Which doctor is referring you to us? _____

SS# _____ Who is your primary care doctor? _____

Reason for 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 / Psycho logic

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

Ears, Nose, Throat

- () Visual changes
- () Vision loss
- () Hearing changes

Other

- () Trauma _____

Respiratory

- () Cough
- () Short 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

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 per week? _____ For how long? _____

Family History (list disease family member had or 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