Vascular & General Surgical Specialists of SWFL- VGSS

Last Name: _____ First Name: _____

Reason for your visit? _____

Have you ever been a patient in this practice before? ☐ Yes ☐ No, if Yes, When: _____

Referring Physician: _____Phone #:_____

Primary Care Physician: _____Phone #:_____

Smoking Status: ☐Former Quit? _____ ☐Never a smoker ☐Current Smoker If yes, #Packs/Day_____

Do you chew tobacco: ☐Yes ☐No

Drinking Status: ☐Non-Drinker ☐Yes, Liquor ____ Beer ____ Wine____ How Much? _____

Past Illnesses of Yourself and Family: Please check if applicable

Condition	Self	Father	Mother	Siblings	Grandparents
Anemia					
Aneurysms					
Amputation					
Bleeding Problems					
Cancer					
Diabetes					
Emphysema					
Gallstones					
Heart Disease					
Heart Attack					
Hypertension					
Hepatitis					
Stroke					
Ulcers					

ROS- Please check all that apply

GENERAL **___ Fatigue** **___ Generalized Weakness** **___ Dizziness** **___ Marked Weight Loss / Gain**	**HEART** **___ Chest pain or Angina** **___ Atrial Fibrillation** **___ Murmur** **___ Pacemaker / Defribillator** **___ Congestive Heart Failure** **___ Syncope (Fainting)**	**MUSCOLOSKELETAL** **___ Muscle cramps / Leg cramps** **___ Back pain** **___ Joint swelling / stiffness** **___ Arthritis** **___ Difficulty walking**
HEENT **___ Glasses/ Contacts** **___ Loss of Vision** **___ Hoarseness** **___ Difficulty Hearing** **___ Ringing in Ears**	**GASTROINTESTINAL** **___ Liver problems** **___ Heartburn/ Reflux** **___ Constipation / Diarrhea** **___ Abdominal pain** **___ Nausea / Vomiting**	**VASCULAR / SKIN** **___ Pain in legs when walking** **___ Unhealing wounds** **___ Amputation** **___ Varicose Veins** **___ Swelling legs / Ankles** **___ Coolness / Discoloration** **___ Redness**
RESPIRATORY **___ Shortness of breath** **___ Asthma** **___ COPD** **___ Chronic Cough** **___ Oxygen Dependent**	**NEUROLOGICAL** **___ Stroke** **___ Mini Stroke / TIA** **___ Frequent headaches / migraines** **___ Numbness tingling of arms/legs** **___ Poor Balance** **___ Spinal Stenosis**	**___ Anxiety** **___ Depression** **___ Memory Loss** **___ Urine burning / pain / frequency** **___ Erectile Dysfunction** **___ Easy Bruising** **___ Blood clots**

Name: _____ DOB: _____

Vascular & General Surgical Specialists of SWFL

PAST SURGICAL HISTORY	DATES	HOSPITAL/PHYSICIAN

List ALL Current & Past Medical History	DATES/DIAGNOSED	PHYSICIAN TREATING YOU/STATUS

Name:_____ DOB:_____

MEDICATIONS: **PRESCRIPTIONS & OVER THE COUNTER**

Medication Name	Dosage	Times per day	Indication (Reason for taking it)

ALLERGIES

Medications	**Reaction**
IODINE (x-ray dye / contrast): YES NO LATEX: YES NO ADHESIVES: YES NO	
OTHERS:	