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 ☐Never a smoker ☐Current Smoker If yes, #Packs/Day____________________

Drinking Status: ☐Non-Drinker ☐Social ☐Moderate ☐Heavy

Do you chew tobacco: ☐Yes ☐No

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					
Hypertension					
Hepatitis					
Stroke					
Ulcers					

Review of Systems: Please check each Item “YES” or “NO” as they relate to your health:

Condition	YES	NO	Condition	YES	NO
Fatigue			Constipation		
Generalized Weakness			Diarrhea		
Dizziness			Abdominal Pain		
Weight Loss / Gain			Black or Bloody BM		
Glasses/Contacts			Numbness in fingers, toes, legs or hands		
Loss of Vision			Weakness in arms/legs		
Hoarseness			Poor balance		
Difficulty Hearing			Headaches		
Ringing in Ears			Joint Pain/stiffness		
Persistent cough			Swelling legs/ankles		
Shortness of breath			Varicose Veins		
Asthma			Spider Veins		
Chest pain			Pain/cramps in legs or buttocks when walking		
Palpitations			Non-healing leg / foot ulcers		
Fainting Spells			Coolness / discoloration		
Atrial Fibrillation			Blood clots		
Murmur			Difficulty Sleeping		
Pacemaker			Memory Loss		
Slurred speech			Urine burning / pain / frequency		
Heartburn/Reflux			Blood in Urine		
Nausea / Vomiting			Erectile Dysfunction		

Name: ______________________________ DOB: ______________________________

Vascular & General Surgical Specialists of SWFL

PAST SURGICAL HISTORY	DATES	HOSPITAL/PHYSICIAN

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

Name:____ DOB:____________________________________

MEDICATIONS: PRESCRIPTIONS & OVER THE COUNTER

Name of Medications	Dosage Mg/mcg	Times per day	Date started	Date stopped

ALLERGIES

Medications	Reaction