1836 Florida Avenue
Panama City, Florida 32405

VASCULAR ASSOCIATES, LLC
The Artery and Vein Experts

10800 PCB Parkway, Unit #300
Panama City Beach, Florida 32407

Ph: (850) 872-8510 • www.ArteryandVeins.com • Fax: (850) 872-7412

"Committed to making a difference in the quality of life in those we serve and those with whom we work"

Patient Information

Today's Date:_____

Social Security Number:____-___-____

First Name: _____ M.I. _____ Last Name: _____ Suffix:_____

Gender: ☐ Male or Female ☐ Date of Birth: ____/____/____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐

Race: _____ Ethnicity: Not Hispanic/Latino or Latino/Hispanic Primary Language: _____

Mailing Address:_____ Apt./Unit#: _____

City: _____ State: _____ Zip: _____

☐ **Check if Physical Address is the same as the mailing address, if not please complete:**

Physical Address:_____ Apt./Unit#: _____

City: _____ State: _____ Zip: _____

Email Address: _____

***Please list phone number in the order in which you would like to be contacted. Thank you!**

1st: (_____) _____ ☐Home ☐Cell ☐Work (**this number will be used for confirmation calls)**

2nd: (_____) _____ ☐Home ☐Cell ☐Work

3rd: (_____) _____ ☐Home ☐Cell ☐Work

Emergency Contact: _____ _____ (_____) _____
Name **Relationship** **Phone**

Pharmacy: _____ _____ (_____) _____
Name **Address** **Phone**

Primary Care Physician: _____

Please continue on reverse side

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Health History:

Patient Name: _____ **DOB:**_____ **Today's Date:**_____

Referring MD: _____ **Primary Care Physician:** _____
Cardiologist: _____ **Neurologist:** _____
Nephrologist: _____ **Other Physicians:** _____
Reason for visit: _____

Allergies: Yes (Please list below with reaction)**/No** (No Known Drug Allergies)

1)_____ 2) _____ 3) _____ 4) _____

Are you allergic to IV Contrast, Iodine or Shellfish? ☐**YES / NO**☐
Are you allergic to Latex? ☐**YES / NO**☐

Social History (Please check/circle all that apply)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Children: ☐Yes / No☐
Currently Living: ☐ Alone ☐ With Family ☐ With Friends ☐ With Significant Other
Profession: ☐Working _____ ☐ Retired
Smoker: ☐Yes / No☐ Past or Present Quit Date: _____
Type: Cigars/Pipe/Cigarettes How many? #_____Pack/Day How Long? _____(Years)
Alcohol: Y / N ☐ Daily ☐ Weekends ☐ Socially

Family History (Please check all that apply and include family member)

☐ Aortic Aneurysm (AAA)_____ ☐ Heart Disease/Attack_____ ☐ Diabetes_____
☐ Cancer_____ ☐ Stroke_____ ☐ DVT (blood clots)_____
☐ Arterial Disease of Legs_____ ☐ Varicose Veins_____ ☐ Bleeding Disorder_____

Patient Surgical History (Please check all that apply and include year)

☐ Angioplasty/Stenting of the leg _____ (year)
☐ Arterial Bypass of the Leg _____ (year)
☐ Aortic Aneurysm Repair _____ (year)
☐ Thrombolysis/Thrombectomy (clot busting) _____ (year)
☐ Sclerotherapy _____ (year)
☐ Vein Stripping _____ (year)
☐ Heart Surgery/Stenting/Bypass _____(year)
☐ Carotid Artery Surgery/Stent _____ (year)
☐ IVC Filter Placement _____ (year)
☐ Saphenous Vein Harvesting _____ (year)
☐ Phlebectomy _____ (year)
☐ EVLT/Thermal Ablation of Veins _____ (year)

☐ Any other surgeries (including year)_____

_____

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Medical History (Check all that apply)

- ☐ Raynaud's Disease
- ☐ Varicose Veins
- ☐ Chronic Renal Failure
- ☐ Carotid Stenosis
- ☐ Heart Attack/CAD/Angina
- ☐ Abdominal Aneurysm (stomach)
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Kidney problems
- ☐ TIA
- ☐ HIV/AIDS
- ☐ Heart Valve Disease
- ☐ High blood pressure
- ☐ Bleeding Disorder
- ☐ Peripheral vascular disease
- ☐ Clot in lung/legs (DVT/PE)
- ☐ Cancer

Are you Currently on Dialysis? ☐ **YES or NO** ☐ Hemodialysis **or** Peritoneal Dialysis?

If Yes, Where: _____ What days? Mon, Wed, Fri (or) Tues, Thurs, Sat ☐ ☐ ☐ ☐ ☐ ☐

REVIEW OF SYSTEM (Check all that apply)

Constitutional

☐ Fatigue ☐ Unexplained weight loss

Eyes, Ears, Nose & Throat

☐ Blurry vision ☐ Loss of vision in one eye ☐ Hearing loss ☐ Nose-bleeds

Psychological symptoms

☐ Depression ☐ Anxiety ☐ Insomnia

Neurological

☐ Seizures ☐ Fainting (syncope) ☐ Difficulty in balance

Respiration

☐ Shortness of Breath ☐ Wheezing ☐ Cough

Cardiovascular

☐ Chest Pain ☐ Heart Palpitation ☐ Irregular Heartbeat

Gastrointestinal

☐ Abdominal Pain ☐ Change in Appetite ☐ Heartburn

Musculoskeletal

☐ Leg pain ☐ Leg swelling

Endocrine

☐ Excessive sweating ☐ Excessive Thirst

Hematological

☐ Blood Clotting ☐ Easy bruising

Printed Name_____

Signature of Patient/ Legal Representative:_____ Date:_____

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Medication List

Patient Name: _____ **DOB**:_____
Today's Date:_____

Please check if you are on any of the following medications and fill in the dosage you are taking:

☐ Medication containing Metformin/Glucophage _____mg

☐ Plavix_____mg ☐ Aspirin _____mg ☐ Warfarin/Coumadin _____mg ☐ Xarelto _____mg

☐ Arixtra/Lovenox_____mg ☐ Pradaxa _____mg ☐ Any other blood thinner _____-___mg

Please list any other medications you are currently taking, the dosage and how often (you may attach printed or typed sheet):

Medication Name	**mg/mcg & times per day**
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	
11)	
12)	
13)	
14)	
15)	

Please continue on reverse side

VASCULAR ASSOCIATES, LLC

Patient Self-Assessment

Patient Name (print):_____DOB:_____

This form is to assess your symptoms and whether conservative treatment has provided any relief. Medicare and other insurance companies require documentation of a significant decline in your quality of life in order to authorize coverage for more aggressive treatment. In order for us to be able to treat unresolved symptoms, it is important for this form to be as accurate as possible. We may ask you to reassess your symptoms as you move forward in our care.

My Leg Symptoms (check all that apply):

☐ **Tiredness** ☐ **Heaviness** ☐ **Cramping** ☐ **Pain/achiness** ☐ **Itching**

☐ **Restless Legs** ☐ **Swelling** ☐ **Burning** ☐ **Bulging, ropey veins**

☐ **Bleeding from Visible Veins** ☐ **Skin Discoloration or texture changes**

Do you have pain when walking: ☐ **Yes / No** ☐
If yes how far can you walk before the pain starts_____

Symptoms are felt in the: ☐ **Left leg** ☐ **Right leg** ☐ **Both legs**

Which leg is worse: ☐ **Left** ☐ **Right**

Pain intensity: None ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** **(worst)**

How long have you had these issues_____ **Years/Months/Days**

My symptoms affect my quality of life in the following areas: (check all that apply)

☐ **Work** ☐ **Socializing** ☐ **Exercise** ☐ **Hobbies**

☐ **Caring for family** ☐ **Housework** ☐ **Sleep** ☐ **Other** _____

The following things worsen my symptoms: (check all that apply)

☐ **Prolonged Sitting** ☐ **Prolonged Standing** ☐ **Walking**

☐ **Driving** ☐ **Elevation** ☐ **Compression hose**

I have tried the following to relieve my symptoms: (check all that apply)

☐ **Wound Care** ☐ **Weight Loss (____lbs)** ☐ **Frequent Elevation** ☐ **Compression hose**

☐ **Exercise** ☐ **Prescription Medication** ☐ **Non-prescription Pain Medication**

I have worn graduated compression stockings/socks for:

☐ **More than 3 months** ☐ **Less than 3 months** ☐ **Other**_____

Patient Signature_____ **Todays Date** _____