PLEASE COMPLETE & BRING WITH YOU TO YOUR APPOINTMENT

PARAGON HEALTH P. C. dba ADVANCED VASCULAR SURGERY

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Note: This is a confidential record and will be kept in our office. This information will not be released to anyone without your authorization. (269) 492-6500 or 1 (800) 448-9684

Name: _____ Birth date: _____ Sex: _____ Age: _____ Race: _____
(First) (M.I.) (Last) (mm) (dd) (yyyy)

Address: _____ City: _____ Zip: _____-_____

Home Phone ( )_____ Work Phone: ( )_____ Cell: ( )_____

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

Please list names of physicians you are currently seeing: _____

_____

Hospital Preference: Borgess ( ) Bronson ( )

Reason for coming to our practice: _____

_____

_____

Medications: (List those you are now taking or attach a list)

Name of Medication: Dosage:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Allergies: Are you allergic to any food or medication? Please circle: Yes or No

Allergy to: Reaction:

1._____
2._____
3._____
4._____
5._____

Patient Name: _____ Date of Birth: _____

History of Past and Present Medical Conditions

Do you now, or have you in the past, had any of the following? Please circle "yes" or "no"

Migraine Headaches	Yes	No	When _____
Epilepsy of convulsions	Yes	No	When _____
Stroke	Yes	No	When _____
Glaucoma	Yes	No	When _____
Cataracts	Yes	No	When _____
Asthma	Yes	No	When _____
Chronic Bronchitis	Yes	No	When _____
Tuberculosis	Yes	No	When _____
Pneumonia	Yes	No	When _____
Emphysema	Yes	No	When _____
Heart attack	Yes	No	When _____
Congestive heart failure	Yes	No	When _____
Rheumatic fever	Yes	No	When _____
Pacemaker	Yes	No	When _____
High blood pressure	Yes	No	When _____
Stomach or duodenal ulcer	Yes	No	When _____
Vomiting blood	Yes	No	When _____
Rectal bleeding	Yes	No	When _____
Colon or bowel trouble	Yes	No	When _____
Kidney problems	Yes	No	When _____
Phlebitis	Yes	No	When _____
Blood clots in arteries	Yes	No	When _____
DVT/Deep Vein Thrombosis	Yes	No	When _____
PE/Pulmonary Embolism	Yes	No	When _____
Diabetes	Yes	No	How long _____
Gout	Yes	No	When _____
High cholesterol	Yes	No	When _____
High triglycerides	Yes	No	When _____
Thyroid-overactive	Yes	No	When _____
Thyroid-underactive	Yes	No	When _____
Nervous breakdown	Yes	No	When _____
Cancer	Yes	No	When _____
Do you have any blood diseases?	Yes	No	When _____

Operations: Were any of the following operated on? *Please circle "yes" or "no". If known, list date and city or hospital*

Tonsils	Yes	No	When _____
Appendix	Yes	No	When _____
Gall Bladder	Yes	No	When _____
Stomach	Yes	No	When _____
Kidney	Yes	No	When _____
Colon	Yes	No	When _____
Thyroid	Yes	No	When _____
Hernia	Yes	No	When _____
Varicose veins	Yes	No	When _____
Heart bypass	Yes	No	When _____
Heart angioplasty	Yes	No	When _____
Heart stent	Yes	No	When _____
Back	Yes	No	When _____

Patient Name:_____ Date of Birth:_____

Operations: Were any of the following operated on? *Please circle "yes" or "no".If known, list date and city or hospital*

Arteries	Yes	No	When_____
Breast	Yes	No	When_____
Uterus	Yes	No	When_____
Ovaries	Yes	No	When_____
Prostate	Yes	No	When_____
Kidney transplant	Yes	No	When_____
Dialysis graft	Yes	No	When_____
Dialysis catheter	Yes	No	When_____

Other_____

Family History

Has any blood relative ever had any of the following? *Please circle "yes" or "no"*

AAA/Abdominal Aortic Aneurysm	Yes	No	Who_____
Blood clots/DVT	Yes	No	Who_____
Cancer	Yes	No	Who_____
Diabetes	Yes	No	Who_____
Heart trouble	Yes	No	Who_____
High blood pressure	Yes	No	Who_____
Stroke	Yes	No	Who_____
Bleeding disorder	Yes	No	Who_____
Varicose veins	Yes	No	Who_____
Vascular disease	Yes	No	Who_____

Other_____

Personal and Social History

Please circle response

Marital Status:	Married	Single	Divorced	Widowed
Any children?	Yes	No	Number of children_____	Your occupation_____
Do you smoke?	Yes	No	If yes, what?_____	How much?_____
Do you drink?	Yes	No	How much?_____	
On a special Diet?	Yes	No	If yes, what kind?_____	

System Review

Circulatory System: Do you or did you experience any of the following? *Please circle "yes" or "no"*

Coldness	Yes	No	If yes, where?_____
Change in skin color	Yes	No	If yes, where?_____
Daytime leg cramps	Yes	No	How far can you walk before cramps occur?_____
Nightime leg cramps	Yes	No	_____
Nightime foot cramps	Yes	No	
Varicose veins	Yes	No	If yes, where?_____
Skin ulcerations	Yes	No	If yes, where?_____

Constitutional

Please circle "yes" or "no"

Fever	Yes	No
Chills	Yes	No
Weight loss	Yes	No

Allergies

Please circle "yes" or "no"

Seasonal	Yes	No
Food	Yes	No

If yes, what?_____

Other_____

Patient Name:_____ Date of Birth:_____

SYSTEM REVIEW

Neurological-

Vision Changes:		
Blurring	Yes	No
Loss of vision in an eye	Yes	No
Double vision	Yes	No
Dizziness	Yes	No
Difficulty with balance	Yes	No
Weakness (one side of body)	Yes	No
Numbness	Yes	No
Passing out spells	Yes	No
Speech difficulty	Yes	No
Memory loss	Yes	No

Heart-

Shortness of breath at night	Yes	No
Swollen ankles	Yes	No
Chest pains with exercise	Yes	No
Unusual heartbeats/palpitation	Yes	No

Lungs-

Coughing up blood	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
On exertion	Yes	No
At rest	Yes	No
Frequent cough	Yes	No

Gastrointestinal-

Poor appetite	Yes	No
Indigestion or heartburn	Yes	No
Abdominal pains	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Recent change in bowel habits	Yes	No
Black, tar-like stools	Yes	No

Genitourinary-

Pain or blood when urinating	Yes	No
Difficulty urinating	Yes	No
Straining to urinate	Yes	No
Kidney failure	Yes	No
Prostate trouble	Yes	No
Difficulty having erections	Yes	No
Difficulty maintaining erections	Yes	No

Bones & Joints-

Painful joints	Yes	No
Swollen joints	Yes	No
Broken bones	Yes	No

Breasts-

Breast lumps	Yes	No
Nipple discharge	Yes	No

Hematological-

Excessive bleeding	Yes	No
Excessive bruising	Yes	No
Abnormal clotting	Yes	No

_____ _____

(Patient's Signature / or Legal Guardian's Signature (Date)

_____ _____

(Physician's Signature) (Date)

CONST - 2	SKIN - 1	EYES - 1	NECK - 1	CARDIO - 8
RESP - 2	GI - 3	NEURO - 1	EXTR - 1	MUSC - 1

updated 10/21/11