Welcome to Vascular Institute!

We are OBSESSED with Patient Care! It all starts with getting to know you, to ensure we provide the best possible care. There is a lot here, but we know you can do it! Please fill out the information below as completely as possible. As always, if you have any questions, all of us will help (but maybe not all of us at once).

Patient Name: _____ Date of Birth: _____

Past Medical History

Please indicate if you have had any of the following by marking the corresponding check box.

Cardiovascular

- ☐ Heart Disease
- ☐ Stroke
- ☐ Myocardial Infarction (Heart Attack)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Chest Discomfort
- ☐ Angina
- ☐ Palpitations
- ☐ Arrhythmia (skipped heart beats)
- ☐ Fluttering feeling in chest
- ☐ Atrial Fibrillation (rapid heart rate)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (heart disease)
- ☐ Swelling in ankles or feet

Ear, Nose and Throat

- ☐ Ear, nose, throat problems
- ☐ Eye Disease
- ☐ Hearing Impaired
- ☐ Allergies

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Autoimmune Disorder
- ☐ Kidney Disease

Musculoskeletal

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness

Infectious Disease

- ☐ HIV
- ☐ Hepatitis
- ☐ C-diff

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Sleep Apnea

Neurological

- ☐ Neurological Disease
- ☐ Epilepsy
- ☐ Chronic Headaches
- ☐ Numbness and Tingling
- ☐ Alzheimer's / Dementia
- ☐ Multiple Sclerosis
- ☐ Memory Loss

Psychiatric

- ☐ Anxiety
- ☐ Depression

Other

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ Thoracic/Abdominal Aneurysm

Vascular

- ☐ DVT
- ☐ Venous Insufficiency
- ☐ Peripheral Artery Disease

Cancer

- ☐ Cancer (specify type below)

  _____

- ☐ Cancer Treatment (specify below)

  _____

Past Surgical History

Please indicate if you have had any of the following by marking the corresponding check box.

Cardiac Surgery
- ☐ Heart Bypass
- ☐ Heart Stents
- ☐ Pacemaker
- ☐ Cardioversion
- ☐ Mitral Valve Replacement
- ☐ Other Cardiac Surgery:

_____

Musculoskeletal Surgery
- ☐ Orthopedic Surgery
- ☐ Back Surgery
- ☐ Shoulder Surgery
- ☐ Foot Surgery
- ☐ Knee Surgery

Genitourinary Surgery
- ☐ Genitourinary Surgery
- ☐ Renal Surgery
- ☐ Prostate Surgery
- ☐ Vasectomy

***Woman Only**
- ☐ Hysterectomy
- ☐ Lumpectomy / Mastectomy

Vascular
- ☐ Carotid Surgery
- ☐ Aneurysm Surgery
- ☐ Angioplasty/Stents
- ☐ Amputation
- ☐ Vein Ablation
- ☐ Other Vascular Surgery:

_____

Gastrointestinal Surgery
- ☐ Gastrointestinal Surgery
- ☐ Ulcer Surgery
- ☐ Appendectomy
- ☐ Colectomy
- ☐ Cholecystectomy
- ☐ Hernia Surgery

Other Surgeries

_____
_____
_____

Social Use

Do you smoke cigarettes or e-cigarettes (“vape”)? ☐ No ☐ Yes

If so, how many packs a day or week? _____ How many cigarettes a day? _____

If applicable, at what age did you start? _____ At what age did you stop? _____

Do you drink alcohol? ☐ No ☐ Yes

How many drinks per day? _____

How many drinks monthly?
2 to 4 times a month: _____
3 to 4 times a week: _____
4 or more times a week: ____

Do you use recreational drugs? ☐ No ☐ Yes

If yes, types: _____

_____

Family Medical History

If you have a family history of any of the following, please indicate which family member in the space provided.

Cancer

- ☐ Colon Cancer:
  Who? _____
- ☐ Lung Cancer:
  Who? _____
- ☐ Ovarian Cancer:
  Who? _____
- ☐ Breast Cancer:
  Who? _____
- ☐ Skin Cancer:
  Who? _____
- ☐ Prostate Cancer:
  Who? _____

Heart Disease

- ☐ Heart Disease:
  Who? _____
- ☐ Stroke:
  Who? _____
- ☐ CAD:
  Who? _____
- ☐ Hypertension:
  Who? _____
- ☐ Hyperlipidemia:
  Who? _____

Diabetes/Renal

- ☐ Diabetes:
  Who? _____
- ☐ Renal Disease:
  Who? _____

Respiratory

- ☐ Asthma:
  Who? _____
- ☐ Allergies:
  Who? _____
- ☐ COPD:
  Who? _____

Psych/Social

- ☐ Psychiatric Problems:
  Who? _____
- ☐ Depression:
  Who? _____
- ☐ Substance Abuse:
  Who? _____

Neurology

- ☐ Alzheimer's / Dementia
  Who? _____
- ☐ Neuropathy
  Who? _____

Other

- ☐ Osteoporosis:
  Who? _____
- ☐ Anemia:
  Who? _____
- ☐ Arthritis:
  Who? _____
- ☐ Thyroid Disease:
  Who? _____

Vascular

- ☐ Abdominal Aneurysm:
  Who? _____
- ☐ Thoracic Aneurysm:
  Who? _____

Patient Health Checklist

Please indicate whether you have experienced any of the following…

General

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Malaise
- ☐ Weight loss

ENT

- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision loss
- ☐ Cataracts
- ☐ Ear ringing
- ☐ Diminished hearing
- ☐ Sore throat

Cardiovascular

- ☐ Chest discomfort
- ☐ Chest pains
- ☐ Palpitations
- ☐ Skipped heartbeat
- ☐ Swelling in ankles or feet
- ☐ Fluttering feeling in chest

Respiratory

- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Asthma
- ☐ Wheezing

Extremities

- ☐ Edema
- ☐ Open ulcers
- ☐ Gangrene
- ☐ Discolored or blue skin

Gastrointestinal

- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Blood in stool

Genitourinary

- ☐ Loss of bladder
- ☐ Blood in urine
- ☐ Burning when urinating
- ☐ Urinary frequency

Musculoskeletal

- ☐ Arthritis
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle weakness

Skin

- ☐ Skin rash
- ☐ Itching
- ☐ Dryness
- ☐ Lesion
- ☐ Suspicious lesions
- ☐ Ulcer

Neurological

- ☐ Memory loss
- ☐ Seizures
- ☐ Vertigo
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Stroke

Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Unusual stress
- ☐ Mental disturbance

Endocrine

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Hematology/Lymphatic

- ☐ Breast mass/lump
- ☐ Enlarged lymph nodes
- ☐ Unexplained bruising

Allergy/Immunologic

- ☐ Hay fever
- ☐ Dust/pollen allergies
- ☐ Persistent infections

Infectious Disease:
Exposed to or been recently diagnosed with… (circle one)

C-diff (Clostridium difficile)
YES NO

Hepatitis
YES NO

HIV
YES NO

MRSA
YES NO

If you circled YES for any of the above, please explain:

_____

_____

_____

Medication / Allergy History

Are you currently taking Aspirin? ☐ Yes ☐ No

Please list all MEDICATIONS you take routinely (including current and previous chemotherapy):

Name of Medication	Dosage (mg)	How many times daily

Medication Allergies:

_____

_____

Other Allergies:

_____

_____

Immunizations:

When was your last flu shot? _____

When was your last pneumonia shot? _____

Have you received the Covid 19 Vaccination? _____

Demographic Information

Patient's Name: _____
Last First Middle Initial

Address: _____ City: _____State: _____Zip: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Cell: _____ Work: _____

Social Security #: _____ Email Address: _____

Permissions: ☐ Home ☐ Mobile ☐ Work *I grant permission to have voice and/or text messages which may contain personal health information left on the phones selected.*

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Release of Records: *I hereby authorize Vascular Institute to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to my emergency contact.*

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

Occupation: _____ ☐ Employed ☐ Retired ☐ Student: ☐ Full Time ☐ Part Time

In order for our healthcare practice to meet the qualification requirements under the American Recovery and Reinvestment Act of 2009 we are required to obtain the following information:

1. Ethnicity ☐ Hispanic or Latino/a ☐ Non-Hispanic ☐ Do not wish to respond
2. Race: ☐ American Indian or Alaska Native ☐ Black or African American
   ☐ Asian ☐ White ☐ Other Race
   ☐ Native Hawaiian or Other Pacific Island ☐ Hispanic ☐ Do not wish to respond
3. Language: ☐ English ☐ Spanish ☐ Other: _____

List Preferred Pharmacy

Pharmacy Name: _____ Location: _____

Phone Number: _____ Fax: _____

Physician Information

Primary Care Physician

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Referring Physician

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Additional Physicians

Cardiologist: _____

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Specialty: _____

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Specialty: _____

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Release of Records:	I hereby authorize Vascular Institute to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to the physicians above.

Insurance Information

Primary Insurance: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policyholder's Name: _____

Date of Birth: _____ Phone: _____ Social Security#: _____

If different from patient:

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone#: _____

Secondary Insurance: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policyholder's Name: _____

Date of Birth: _____ Phone: _____ Social Security#: _____

If different from patient:

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone#: _____

Responsible Party **- Person responsible for receiving the financial statements.**

☐ **SELF**

☐ **Other - Please complete information below**

Name:

_____

Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone#: _____ Secondary Phone#: _____

Date of Birth: _____ Email Address: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Vascular Institute to release health/medical information of:

Patient's Full Name: _____ Date of Birth: _____

This information is to be released to:

Recipient:_____Relationship to patient:_____

Phone Number: _____

Recipient:_____Relationship to patient:_____

Phone Number: _____

Recipient:_____Relationship to patient:_____

Phone Number: _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc., unless herein except:

_____

This release includes all documents created by Vascular Institute, such as but not limited to:

- Office, Chart & Progress Notes
- Ultrasound Reports
- All documents that Vascular Institute has ordered on your behalf.

Covering records from:

- The date of its creation by Vascular Institute, whether in the past or future.

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNLESS OTHERWISE REVOKED.

Signature (person authorizing release): _____

Date of Signature: _____ Relationship to Patient: _____

Advanced Medical Directive and Power of Attorney

Do you have an Advance Medical Directive? ☐ Yes ☐ No *(You Must Check One)*

If yes, Name: _____

Phone: _____

Do you have a Healthcare Medical Power of Attorney? ☐ Yes ☐ No *(You Must Check One)*

If yes, Name: _____

Phone: _____

Insurance and Payments

Financial Responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by our specific network agreement with your insurance carrier, if such an agreement is in place.

If you do not have health insurance, or if your health insurance will not pay for services rendered by us or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

By initialing this section, you acknowledge that you have received a copy of our Financial Policies to review. A copy is available at our front desk and online at: www.myvascular.com	Initial:

Additional Notifications

Notice of Privacy Practice	
By initialing this section, I acknowledge that I have received a copy of the Notice of Privacy Practice which includes a Statement of Patient's Rights to review. A copy is available at our front desk and online at: www.myvascular.com	Initial:

Code of Conduct	
By initialing this section, I acknowledge that I have received a copy of the Code of Conduct Statement to review. A copy is available at our front desk and online at: www.myvascular.com	Initial:

Use of Media	
By initialing this section, I acknowledge that I have received a copy of the Use of Media statement to review. A copy is available at our front desk and online at: www.myvascular.com	Initial:

By signing below, I voluntarily consent to all medical and surgical treatment performed by Vascular Institute. I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure, or treatment, and to discuss it with my health care provider. I understand that if an employee or any individual associated with Vascular Institute is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV).

The information on this form is accurate to the best of my knowledge.

_____ _____

Signature of Patient / Legally Authorized Representative Date

_____ _____

Printed Name of Patient / Legally Authorized Representative Relationship to Patient