New Patient Vascular Form

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Date:____/____/____ Patient Name:_____ DOB:____/____/____

Age:_____ Referring physician_____

Primary Care Doctor_____ Cardiologist_____

Nephrologist:_____ **Pharmacy_____

Pharmacy phone #_____ Pharmacy address_____

Chief Complaint:_____

_____

History of Present Illness

Location of pain:_____ **Location of swelling**_____

Describe your type of pain: □ aching □ burning □ cramping □itching □stabbing □ tingling

What helps? □ hose □ rest/elevation □walking □ lying down □ OTC medications □ other_____ □ none

What causes? □ walking □ prolonged sitting □ standing □ other _____ □ none

Severity of pain:_____ (rate from 1-10) **Severity of swelling**:_____(rate from mild to severe)

How long has there been pain?_____ **swelling?**_____

How often do you have pain?_____ **swelling?**_____

What medications help?_____

Do you have any of these symptoms currently? □ dizziness □ slurred speech □ loss of balance □ weakness on one side/both sides □ headaches □ loss of vision/vision changes □ facial drooping

Do you smoke? □ Yes □ No **Have you ever used tobacco?** □ Yes □ No

Have you had your pneumonia vaccine? □ Yes □ No **If not, why?**_____

Have you had a mammogram? □ Yes □ No **Year**_____ **Have you had a colorectal screening?** □ Yes □ No **Year**_____

Have you ever worn support hose? □ Yes □ No **if so, how long?** □ weeks □ months □ years

Dialysis Patients Only

Are you on dialysis? □ Yes □ No When did you last dialyze? _____ Dialyze is sched: _____

Do you currently have a Fistula or Graft? □ Yes □ No if so □ right □ left

Dialyze is sched: □ M □ W □ F □ Tu □ Th □ Sat □ Oth

Do you have a Perma Cath? □ Yes □ No any pain? _____(1-10) swelling? _____(mild to severe)

Current Medications

Drug	Dosage	Number of times per day

Do you have any drug allergies? _____

Personal Medical History (Please mark the year you were diagnosed in the box provided)

Condition	Year	Condition	Year		
Cardiovascular		**Renal/ Genitourinary**		Headaches/ Migraines	
Abdominal Aortic Aneurysm		Acute Renal Failure		Tension Headaches	
Aneurysm, other		Bladder Infection		Meningitis	
Angina		Urinary Tract Infection		Mental Retardation	
Arrhythmia		Chronic renal Failure		Multiple Sclerosis	
Arterial Thrombosis		Dialysis		Muscular Dystrophy	
Carotid Artery Stenosis		Enlarged Prostate		Myasthenia Gravis	
Congestive Heart Failure		Erectile Dysfunction		Parkinson's Disease	
Coronary Artery Disease		Kidney Infection		Peripheral Sensory Neuropathy	
Deep Vein Thrombosis		Urinary Incontinence		Seizure Disorder	
Heart Disease		Other_____		Stroke	
High Cholesterol		**Musculoskeletal**		Transient Ischemic Attack (TIA)	
High Blood Pressure		Arthritis		**Cancer**	
Heart Attack		Chronic Pain		Bone Cancer	
Irregular Heartbeat		Fibromyalgia		Brain Tumor	
PAD/ Atherosclerosis		Fracture		Breast Cancer	
Superficial Phlebitis		Gout		Colon Cancer	
Varicose Veins		Osteoarthritis		Hepatic Carcinoma (Liver)	
Venous Insufficiency		Osteoporosis		Leukemia	
Lymphedema		Rheumatoid Arthritis		Lung Cancer	
Pulmonary		Lupus		Lymphoma	
Asthma		**Endocrine**		Melanoma	
Chronic Bronchitis		Addison's Disease		Pancreatic	
COPD		Diabetes Insulin Dependent		Prostate	
Cystic Fibrosis		Diabetes Non Insulin Dependent		Renal (Kidney)	
Emphysema		Hepatitis		Skin	
Lung Infection		Hyperthyroidism		Testicular	
Pneumonia		Jaundice		Thyroid	
Pulmonary Embolism		Enlarged Thyroid		Other_____	
Pulmonary Hypertension		Other_____		**Other**	
Sleep Apnea		**Hematology**		Allergies	
Tuberculosis		Bleeding Disorder		Chicken Pox	
Gastrointestinal		Hemolytic Anemia		HIV	
Cirrhosis of Liver		Iron Deficiency Anemia		Immunodeficiency	
Colitis		Pernicious Anemia		Infectious Disease	
Colon Polyps		_____ Anemia		**Other**	
Diverticulitis		Other_____		Cataract	
Hepatitis		**Neurological**		Glaucoma	
Hemorrhoids		Alzheimer's		Medication Noncompliance	
Indigestion/ Heartburn		Attention Deficit Disorder		Obesity	
Irritable Bowel Syndrome		Attention Deficit Hyperactivity		Ovarian Cysts	
Pancreatitis		Cerebral Palsy		Pregnancy (how many?)	
Reflux		Dementia		**Conditions Not Listed**	
Stomach Ulcer Disease		Depression			
Other_____		Downs Syndrome			

Surgical History

□No surgical history
□Previous anesthesia problems
□Previous blood transfusion

Please mark the year next to the surgical procedure

Surgery	Year	Surgery	Year	Surgery	Year
Breast Surgery		Amputation		Fistulogram	
Bleeding Problems		Heart Cath		Angioplasty	
C-Section		Heart Bypass Surgery		Arteriogram	
Cataract Removal		Heart Stent		Bypass Graft (Extremity)	
Appendectomy		Pacemaker		Carotid Surgery	
Cosmetic Surgery		Defibrillator Placed		ABD Aneurysm Repair	
Hysterectomy		Orthoscopic Surgery		IVC Filter Placed	
Injury Related		Dialysis Graft or Fistula		Perma-cath Placement	
Hemorrhoidectomy		Spider Vein Treatment		Embolectomy	
Tonsils Removed		Varicose Vein Surgery		Stent Placement (renal)	
Tubal Ligation		De-clotting Procedure		Stent Placement (legs)	
Gall Bladder Surgery		Hernia Repair			

Family History

Mother (**M**) Father (**F**) Brother (**B**) Sister (**S**) Aunt (**A**) Uncle (**U**) Maternal Grandmother (**Mat-M**) Paternal Grandmother (**Pat-M**) Maternal Grandfather (**Mat-F**) Paternal Grandfather (**Pat-F**)

Please mark in the appropriate block which family member has/had the following medical conditions:

Condition	Family Member	Comments	Condition	Family Member	Comments
Carotid Stenosis			Aneurysm		
Stroke/ TIA			Diabetes		
Cancer			PVD		
Varicose/ Spider Veins			Renal Failure		
Venous Disease			Blood Clot		
High Blood Pressure			High Cholesterol		
Heart Disease			Bleeding Disorder		
Lung Problems			COPD		
Hepatitis B/C			Parkinson's Disease		
Multiple Sclerosis			Alzheimer's		
Hyperthyroidism			Hypothyroidism		

Social History

Information obtained from: □ patient □ spouse □ parent □ significant other □ sibling □ child □ caretaker □ other

Marital Status: □married □divorced □single □widowed **Number of children**: _____
Other living arrangements: □assisted living □nursing home □other:_____
Do you exercise? □Yes □No

Alcohol Use: □denies use □yes-social □yes-daily
Tobacco Use: □never □previously stopped packs/day _____ # of years _____
□currently smoking packs/day_____ # of years _____
Substance Use: □never □yes type: _____ frequency: _____
Have you ever worn support hose? □yes □no if so, how long? _____

Review of Systems (to be completed by patient)

General
___ Weight Gain
___ Weight Loss
___ Fever
___ Fatigue
___ None apply

Eyes
___ Cataracts
___ Glasses/contacts
___ Impaired
___ Redness
___ Vision changes
___ None apply

Ear/Nose/Throat
___ Bad breath
___ Ear disease
___ Ear injury
___ Hearing impairment
___ Mouth sores
___ Nose bleeds
___ Sinus problems
___ Sneezing
___ Sore throat
___ Voice changes
___ None apply

Genitourinary
___ Burning
___ Sexual activity (impotence)
___ Incontinence
___ Urgency
___ Blood in urine (hematuria)
___ Renal failure
___ None apply

Allergic/Immunity
___ Allergic reaction
___ Seasonal allergies
___ None apply

Psychiatric
___ Depression
___ Memory changes
___ Sleep disturbances
___ Anxiety
___ None apply

Hematol/Lymphatic
___ History of blood transfusions
___ Slow to heal
___ Enlarged glands
___ Anemia
___ Excessive bleeding
___ Easy bruising
___ None apply

Gastrointestinal
___ Abdominal pain/swelling
___ Appetite changes
___ Bloody or black stools
___ Bowel movement changes
___ Constipation
___ Diarrhea
___ Acid reflux
___ Heartburn/indigestion
___ Nausea
___ Vomiting
___ Rectal swelling/bleeding
___ Dysphasia
___ Bloating
___ Trouble swallowing
___ Vomiting blood
___ None apply

Cardio Respiratory
___ Chest pain
___ Difficult breathing
___ Palpitations/irregular rhythm
___ Shortness of breath
___ Swelling of feet/ankles
___ Heart murmur
___ Sleep disturbances
___ High blood pressure
___ None apply

Skin
___ Scars
___ Varicose veins
___ Open wounds
___ Discoloration
___ Dry skin
___ Thick toenails
___ Drainage
___ Hair/nail changes
___ Fungal nail infection
___ Mole changes
___ Rashes
___ Redness
___ Lumps
___ None apply

Extremities
___ Amputations
___ Bone/joint pain or swelling
___ Burning sensations- feet/legs
___ Cold sensations in the feet
___ Cold sensations in he hands
___ Difficulty walking
___ Numbness in arms
___ Numbness in legs
___ Pain in leg/calf when walking
___ Pain in legs at night
___ Swelling of legs/feet
___ Ulcers on arms/hands
___ Ulcers on legs/feet
___ Varicose veins
___ Spider veins
___ Weakness in arms/legs
___ None apply

Neurological
___ Fainting/loss of consciousness
___ Temporary loss of vision
___ Weakness in arms/legs
___ Speech problems
___ Numbness
___ Dizziness
___ Headaches
___ Unsteadiness
___ Tremors
___ None apply

Musculoskeletal
___ Back pain
___ Muscle cramps
___ Muscle weakness
___ Arthritis
___ Hip pain
___ Shoulder pain
___ Knee Pain
___ None apply

Endocrine/Neck
___ Hypothyroidism
___ Hyperthyroidism
___ Enlarged thyroid
___ Enlarged glands
___ Excessive thirst
___ Hot flashes
___ Intolerance to hot/cold
___ Hair loss
___ None apply

STOP HERE! PLEASE DO NOT FILL OUT BEYOND THIS POINT

Physical Exam

Name: _____ **Date:** ____/____/_____

BP: _____/_____ **L-R** **Temp:** _____ **Pulse:** _____ **Resp:** _____ **HT:** ____/____ **WT:** _____

CC: _____

_____

Ulcer □R □L **Location:** □**Ankle** □**Calf** □**Thigh** □**Mid Foot/Heel** □ **Foot or Toe:** □1st digit □2nd digit □3rd digit □4th digit □5th digit

Size: _____ **Depth:** □ **Skin** □**Fat** □**Muscle** □**Bone**

Dominant Hand: □Right □Left **Appearance:** □well developed □well nourished □obese □malnourished □elderly □thin

Grooming: □well groomed □disheveled □unkempt □multiple tattoos □malodorous

Distress: □none □ILL appearing □in pain □lethargic □appearing tired □tearful □toxic appearing

Eyes: **Glasses:** □Y □Drive only □read only □N **Contacts:** □Y □N **Blind:** □R □L □normal lids □lid edema □redness □PEERLA

Hearing: □normal □ABN□AID □Right ear □Left ear □both □ear disease □ear injury **Nose:**□sinus □tenderness □normal □discolored □on oxygen □spider veins □nose bleeds

Mouth: **Dentures:** □Yes □upper □partial □No **Tonsils:** □Yes □No **Tooth Pain:** □Yes □No

Skin: □clear □dry □pink/healthy □discolored □bruising □spider veins □VV □ulcers □pale

Nails: **Hands:** □normal □pitted □ridged □thick □discolored **Feet:** □normal □pitted □ridged □thick □discolored

Neck: **Bruit:**□R □L □none **Masses:** □Yes □No **Supple:** □Yes □No **JVD:** □normal □abnormal

Respiration: □clear breath sounds □rubs □wheezes □normal □abnormal

Heart: **Murmur:**□Y □N **Rate:**□normal □abnormal **Rhythm:**□normal □abnormal **Bruits:** □Y □N pacemaker/difib

Ambul/Musc: □ambulatory □normal gait □shuffles □slow □stooped □unsteady □cane □walker □wheelchair PA-M

Abdomen: **Bowel sounds:** □Y □N **Masses:**□Y □N **Bruits:** □Y □N flat/rounded/hernia soft/tender/non tender/scars

Neurological: □alert/oriented x3 □confused □trembling □**neuropathy** □hands □feet □none

□ **Stroke:** □L side weakness □R side weakness **Speech:** □normal □loud □stutter □slowed □flat

Psych: □normal mood □depression □anxious □agitated □flat □argumentative □litigious **Flu Vaccine:** □Yes □No

Tobacco Use: □never used tobacco □current amount/freq.____ □previously...how long___ **Pneumonia Vaccine:** □Yes □No

Pressures	Right	Left
Doppler	_____	
PT	_____	
DP	_____	
Index	_____	
Index	_____	

Palpable pulse	Right	Left
PT	Y/N	Y/N
DP	Y/N	Y/N
Radial	Y/N	Y/N
Graft/Fistula	Thrill	No Thrill

Smoking Counseling? ☐Yes ☐No

Physician Recommendations/Orders: _____

_____

ART-UNI ART-BILAT VENOUS-UNI VENOUS-BILAT CAROTID ABDOMINAL VEIN MAP: Upper / Lower HEMODIALYSIS

AVS

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General Consent To Treat

Date: _____

Patient's Name: _____
Date of Birth: _____

- **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her assistants participating in my care. This care may include; diagnostic, laboratory or radiology procedures; anesthesia, therapeutic procedures, nursing, hospital or blood transfusions. I understand I will sign an informed consent IF surgery or surgical procedure is recommended.
- **Release of Information:** I authorize Atlanta Vascular Specialists to release pertinent information and/or copies of medical records for treatment, payment, or health care operation purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDES Related Complex (ARC) and Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records and social work records, if any. See Notice of Privacy Practices for further information.
- **Payment:** I assign and authorize payment from my insurance company directly to Atlanta Vascular Specialists for any and all services rendered. I agree to pay, at the time of competed services all charges not covered by my insurance company. I understand that it is my primary responsibility to pay all charges for services rendered irrespective of any disputes or disagreements between myself and the insurance company.
- **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized. I release Atlanta Vascular Specialists of all responsibility for personal articles which I have with me during the time I am a patient. I understand the office is not responsible for personal articles of value kept in my possession while a patient at the office.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this content will be deemed continuing and I am free to withdraw my consent at any time.

Signature of Patient: _____ Date: _____

Atlanta Vascular Specialists * Vein Specialists of Georgia

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UPDATE 2020- Acknowledgement of Receipt of Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If so, you may obtain a revised copy by contacting Carol Daigle, RN or Connie Dillard, Practice Administrator. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name (please print):_____ DOB: _____

Phone- Home: _____ Cell: _____Work:_____

Messages-please call my: [ ] home [ ] cell [ ] work [ ] other_____

If unable to reach me (choose one):

[ ] you may leave a detailed message [ ] please leave a message asking me to return your call

[ ] other: _____

The best time to reach me is: Day(s): _____Time Range: _____

Release of Information

PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL PIEDMONT HEALTHCARE HOSPITALS, PHYSICIAN GROUPS, PIEDMONT HEALTHCARE AFFILIATED ENTITIES AND PROVIDERS AND NON-PIEDMONT HEALTHCARE AFFILIATED ENTITES AND PROVIDERS.

[ ] I authorize the release of information including diagnostic, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child/Children: _____

[ ] Other: _____

*The release of information will remain in effect until terminated by me in writing.

Signed: _____ Date: _____

Witness:_____ Date:_____