Vascular Specialists of Central Florida, Inc.

Name: _____ Date _____

Date of Birth _____ Weight _____ Height_____

Have you had any diagnostic studies related to today's complaints? ☐ Yes ☐ No
If yes, please list _____

Please mark all that apply and indicate date(s) diagnosed

- ☐ Insulin dependent Diabetes Date _____
- ☐ Non-Insulin dependent Diabetes Date _____
- ☐ Heart disease Date _____
- ☐ Heart attack Date _____
- ☐ High blood pressure Date _____
- ☐ Stroke Date _____
- ☐ Kidney Disease Date _____
- ☐ Kidney Failure Date _____
- ☐ Abdominal aneurysm Date _____
- ☐ Cancer Date _____
- ☐ COPD Date _____
- ☐ Asthma Date _____
- ☐ DVT (Deep Vein Thrombosis) Date _____

****Please list any previous surgeries and date(s)****

_____

_____

Have you ever had difficulties with anesthesia? ☐ Yes ☐ No
If Yes, please explain _____

Date of most recent cardiac stress test _____
Were your results (***please mark***) ☐ normal or ☐ abnormal ?

Date of most recent cardiac catheterization _____
Date of most recent stent _____ Number of stents_____

When was your last pneumovax? _____
When was your last mammogram? _____
When was your last colonoscopy? _____
Family History Mother/Father/or Siblings (**Please mark all that apply and list the family member with the history**)

- ☐ Cancer ☐ Deep Vein Thrombosis ☐ Diabetes
- ☐ Heart disease ☐ Stroke ☐ AAA (abdominal aneurysm

Name: _____

Occupation _____Marital Status_____
Number of previous pregnancies resulting in live births _____

Do you drink alcohol? ☐ **Yes** ☐ **No**
If Yes, ***(mark one)*** ☐ social drinker ☐2 or fewer drinks/day ☐ three or more drinks/ day

Do you exercise? ☐ **Yes** ☐ **No**
Please choose from one of the choices below:

- ☐ Moderate exercise less than three times week
- ☐ Moderate exercise 3 or more times a week
- ☐ Strenuous exercise less than 3 times week
- ☐ Strenuous exercise 3 or more times week

Have you ever smoked? ☐ **Yes** ☐ **No**
If Yes, If you currently smoke, how many packs/day _____ For how many years _____
Former smoker? How many packs/day_____ For how many years _____ When did you quit smoking?_____

Do you have a history of any of the following? ***(mark all that apply)***

- ☐ Fever
- ☐ Chills
- ☐ Feeling poorly
- ☐ Skin discoloration
- ☐ Rash
- ☐ Sores
- ☐ Swollen lymph nodes in the neck
- ☐ Swollen lymph nodes in the groin
- ☐ Bleeding
- ☐ Recurrent infections
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscles decreasing in size
- ☐ Back pain
- ☐ Headache
- ☐ Malignant Hypertension
- ☐ Dizziness
- ☐ Fainting
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Productive cough
- ☐ Chest Pain/Discomfort
- ☐ Abdominal pain
- ☐ Weakness
- ☐ Numbness
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Nausea
- ☐ Difficulty with Balance
- ☐ Convulsions
- ☐ Poor coordination

Are you allergic to iodine? ☐ **Yes** ☐ **No**
Are you allergic to shellfish? ☐ **Yes** ☐ **No**
Do you have any allergies to medication? ☐ **Yes** ☐ **No**
If Yes, please list the medication and the type of reaction you have when you use it:
_____
_____

Name: _____

Nephrologist's name _____
Name of Dialysis Center_____
Dialysis Center Phone#_____

What days of the week do you go to dialysis? ☐Sun ☐M ☐Tu ☐W ☐Th ☐Fri ☐Sat
What site is being accessed for dialysis? ☐Arm ☐Leg ☐Chest ☐PD

Medication List:(Please include any vitamins, nutritional supplements and alternative medicines)

Medication Name	Dose(milligram or milliliters)	How often(Per Day?)

Pharmacy name: _____
Pharmacy Telephone number: _____

Do you have an advance directive? _____
If yes to above question,
Do you have someone appointed as your health care agent? _____

*****IN CASE OF A SURGICAL EMERGENCY, ARE YOU WILLING TO RECEIVE BLOOD OR BLOOD PRODUCTS? ☐ Yes ☐ No**