Desert Endovascular Center

Patient Name: _____

Name you prefer to be called: _____

Preference for contact: Phone ☐ Email ☐

Best contact phone number: _____

Email address: _____

OPTIONAL:

For continuation of care, please provide the names of your medical care providers below if you would like us to send them our notes from today's visit:

Name of Primary Care Physician: _____

Name of any other Physicians you want to receive your records (ie: oncologist, cardiologist, gynecologist, etc):

_____

PATIENT HISTORY

What brings you to see the doctor today? _____

Do you have other health problems (i.e. diabetes, hypertension, etc.)?_____

_____

_____

Prior Surgery? Type? Date?

_____

_____

_____

_____

_____

Current medications being taken? Dose? Frequency?

_____

_____

_____

_____

Allergic to any medications? _____

Allergic to latex? _____

Do you have cancer? _____

Do you have high blood pressure, chest pain, heart disease or have you had a heart attack?_____

Do you have diabetes? _____

Do you have hepatitis or liver disease? _____

Do you have kidney disease or kidney failure? _____

Do you have asthma, emphysema, or shortness of breath? _____

Do you have depression or other psychiatric conditions? _____

Do you have arthritis, joint pain, numbness or tingling? _____

Do you have lupus or other autoimmune disease? _____

Social History:

Please circle: Single Married Divorced Widowed

Did you bring anyone here with you today? If so, who? _____

Smoke: Yes or No? If yes, how much per day? _____

Previously smoked: Yes or No? If yes, when did you quit? _____

Consume Alcohol: Yes or No? If yes, how much per week? _____

Does anyone else in your family have a history of the same condition that you are seeing the doctor for today? _____