

Name \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_  NEW PT  EST PT NEW PRBLM  CONSULT**HISTORY – COMPLETED BY PATIENT, STAFF OR PROVIDER**

1. Reason for visit today \_\_\_\_\_

2. Patient evaluated at the request of \_\_\_\_\_  Work Related3. Please indicate with  if you have a history of or any current problems or symptoms in any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> General Wellness | <input type="checkbox"/> Heart/Circulation    | <input type="checkbox"/> Blood/Lymph     |
| <input type="checkbox"/> Eyes             | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> Skin             | <input type="checkbox"/> Atrial Fib           | <input type="checkbox"/> TB              |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> AIDS/HIV        |
| <input type="checkbox"/> Psychiatric      | <input type="checkbox"/> HighChlstrl/Lipids   | <input type="checkbox"/> Neurological    |
| <input type="checkbox"/> Ears,Nose,Throat | <input type="checkbox"/> Stomach/Digestion    | <input type="checkbox"/> Stroke/Seizure  |
| <input type="checkbox"/> Lungs/Breathing  | <input type="checkbox"/> Bowel                | <input type="checkbox"/> Thyrd/Endocrine |
| <input type="checkbox"/> MuscleJoint/Bone | <input type="checkbox"/> Reproductive/Urinary | <input type="checkbox"/> Diabetes        |

Comments – Review of Systems

 All other systems negative

4. Medication(s) (drugs, pills): \_\_\_\_\_

5. Previous Surgeries/Dates: \_\_\_\_\_

(attach sheet if necessary)

6. Allergies/Reaction \_\_\_\_\_

7. What is your Social History

Marital Status:  Single,  Divorced,  Married,  Widow/Widower, Who lives with you? \_\_\_\_\_

Current Employer/Occupation? \_\_\_\_\_ What kind of work(lifting on feet)? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many packs a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ #drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_ per month? \_\_\_\_\_ Illicit Drug Use? \_\_\_\_\_ What Type? \_\_\_\_\_

8. What is the Health Status of Your Family?

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_

**Family Illnesses:**History of Heart Disease(heart attack, heart failure) yes no History of Strokes? yes noHistory of high blood pressure? yes no History of diabetes?yes no History of cancer?yes, site \_\_\_\_\_ no**HISTORY – COMPLETED BY PROVIDER**

Chief Complaint: \_\_\_\_\_

History of Present Illness: (Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Assoc. signs/symptoms) (1-3 brief, 4+ extended) OR Status of Chronic or Inactive Conditions (3 or more = extended w/o HPI)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Vascular Patient Questionnaire

LSG005

Do you get leg pain? Yes No If yes, how often do you get this pain?

Describe the type of pain.

What part of your leg? (*Circle all that apply*)

<i>Buttock</i>	Right or Left	<i>Foot</i>	Right or Left
<i>Thigh</i>	Right or Left	<i>Toes</i>	Right or Left
<i>Calf</i>	Right or Left		

When do you get pain? (*Check one*)

- Standing
- Walking Upstairs
- Walking Downstairs

How far can you walk at a fast pace? *Number of Blocks* \_\_\_\_\_

What do you do for the pain? (*Check all that apply*)

- Stop & Rest How long do you rest? \_\_\_\_\_
- Sit down & rest How long do you rest? \_\_\_\_\_
- Legs Elevated
- Legs Down
- Exercise
- Compression Stockings  
*If so for what duration have you tried them # \_\_\_\_\_ weeks or # \_\_\_\_\_ months*
- Take Medication (*Write the name of all medications used to control pain.*)  
Over-the-Counter: \_\_\_\_\_  
Prescription: \_\_\_\_\_

Do you currently work? Yes or No

If yes, does your pain interfere with your work? Yes or No

Explain: \_\_\_\_\_

Describe any previous vascular surgery or studies you have had: (*Did you bring the original films/reports with you?*)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Assistant Initials: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Breast Patient Questionnaire

### Breast:

LSG004

Do you have a lump you can feel? \_\_\_\_ Yes \_\_\_\_ No

Where? \_\_\_\_\_

Have you ever had any nipple discharge in the past year? \_\_\_\_ Yes \_\_\_\_ No

If yes, describe color, quantity, frequency and relationship to your periods: \_\_\_\_\_

Did you breast feed? \_\_\_\_ Yes \_\_\_\_ No

Do you practice self-breast exam? \_\_\_\_ Yes \_\_\_\_ No How often? \_\_\_\_\_

Most recent breast exam: \_\_\_\_\_

When was your first mammogram? \_\_\_\_\_

Date of the most recent mammogram?(mm/dd/yy) \_\_\_\_\_

### Menstruation:

Age when first menstrual period began: \_\_\_\_\_

Do you still get your menses (periods)? \_\_\_\_ Yes \_\_\_\_ No

If no, your age at menopause: \_\_\_\_\_

Date of your last menstrual period: \_\_\_\_\_

Most recent pelvis exam: \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Your age when your first child was born: \_\_\_\_\_

Have you ever taken contraceptives? \_\_\_\_ Yes \_\_\_\_ No If yes, how long? \_\_\_\_\_

Name of contraceptive: \_\_\_\_\_

Have you had a hysterectomy? \_\_\_\_ Yes \_\_\_\_ No Type: vaginal or abdominal (circle)

If yes, when: \_\_\_\_\_

Were your ovaries removed? \_\_\_\_ Yes \_\_\_\_ No

Have you ever had hormonal (i.e. estrogen or progesterone) therapy? \_\_\_\_ Yes \_\_\_\_ No

If yes, what: \_\_\_\_\_

### Describe:

Describe any symptoms associated with your breasts or menses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any relatives who have had breast cancer: (Relationship to you, age at time of diagnosis, present status, if deceased at what age?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe any previous breast surgery or studies you have had: (Did you bring the original films/reports with you?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Assistant Initials: \_\_\_\_\_