Interventional and Vascular Consultants, PC

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Wilsonville Office
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Wilsonville, OR 97070

Date: _____ Patient Name: _____

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

Referring Physician/Specialist: _____

Review of Systems: Please check "yes" or "no" as they relate to your health.

CONSTITUTIONAL

Chills	Y ☐	N ☐
Fever	Y ☐	N ☐
Fatigue	Y ☐	N ☐
Change in appetite	Y ☐	N ☐
Weight Gain	Y ☐	N ☐
Weight Loss	Y ☐	N ☐

EARS/NOSE/THROAT

Vertigo	Y ☐	N ☐
Sore Throat	Y ☐	N ☐
Heartburn	Y ☐	N ☐
Hoarseness	Y ☐	N ☐
Nosebleeds	Y ☐	N ☐
Tinnitus	Y ☐	N ☐

EYES

Eye Pain	Y ☐	N ☐
Spots before eyes	Y ☐	N ☐
Vision Changes	Y ☐	N ☐

RESPIRATORY

Shortness of breath	Y ☐	N ☐
Coughing Blood	Y ☐	N ☐
Wheezing	Y ☐	N ☐
Persistent Cough	Y ☐	N ☐
Frequent Infections	Y ☐	N ☐

CARDIOVASCULAR

Chest Pain	Y ☐	N ☐
Palpitations	Y ☐	N ☐
Swelling of Extremities	Y ☐	N ☐
Hypertension	Y ☐	N ☐

GASTROINTESTINAL

Abdominal Pain	Y ☐	N ☐
Heartburn	Y ☐	N ☐
Rectal bleeding	Y ☐	N ☐
Bloody/Black Stools	Y ☐	N ☐
Diarrhea	Y ☐	N ☐
Constipation	Y ☐	N ☐

ENDOCRINE

Dry skin	Y ☐	N ☐
Abnormal thirst	Y ☐	N ☐

GENITOURINARY

Pain Urinating	Y ☐	N ☐
Blood in Urine	Y ☐	N ☐

MUSCULOSKELETAL

Joint Pain/Swelling	Y ☐	N ☐
Stiffness	Y ☐	N ☐
Muscle Pain	Y ☐	N ☐
Back Pain	Y ☐	N ☐

DERMOTOLOGIC

Rash/Sores	Y ☐	N ☐
Lesion	Y ☐	N ☐
Itching	Y ☐	N ☐

ALLERGY/IMMUNOLOGY

Seasonal Allergy	Y ☐	N ☐
Drug Allergy	Y ☐	N ☐

NEUROLOGICAL

Seizures	Y ☐	N ☐
Headaches	Y ☐	N ☐
Numbness	Y ☐	N ☐

HEMATOLOGIC

Easy Bruising	Y ☐	N ☐
Gums Bleed Easily	Y ☐	N ☐
Enlarged Glands	Y ☐	N ☐
Prolonged Bleeding	Y ☐	N ☐

PSYCHIATRIC

Anxiety	Y ☐	N ☐
Depression	Y ☐	N ☐

Medical History: Please check "Yes" or "No" as they relate to your past medical history.

Hepatitis	Y ☐	N ☐	Previous Anglo/Stent	Y ☐	N ☐	Seizure Disorders	Y ☐	N ☐
HIV/AIDS	Y ☐	N ☐	Pneumonia	Y ☐	N ☐	Gout	Y ☐	N ☐
Rheumatic Fever	Y ☐	N ☐	Diabetes	Y ☐	N ☐	Arthritis	Y ☐	N ☐
Tuberculosis	Y ☐	N ☐	Thyroid Problems	Y ☐	N ☐	Back Pain	Y ☐	N ☐
High Blood Pressure	Y ☐	N ☐	Liver Disease	Y ☐	N ☐	Herniated Disc	Y ☐	N ☐
High Cholesterol	Y ☐	N ☐	Stomach Ulcer	Y ☐	N ☐	Anemia	Y ☐	N ☐
Heart Attack	Y ☐	N ☐	Kidney Disease	Y ☐	N ☐	Blood Clots	Y ☐	N ☐
Irregular Heart Beats	Y ☐	N ☐	Prostate Problems	Y ☐	N ☐	Bleedings Problems	Y ☐	N ☐
Heart Murmur	Y ☐	N ☐	Stroke/ TIA	Y ☐	N ☐	Cancer	Y ☐	N ☐

PLEASE LIST ALL CURRENT MEDICATIONS:

MEDICATION	DOSE	MEDICATION	DOSE

Y ☐ N ☐ Are you currently taking Aspirin? How often? _____

Y ☐ N ☐ Are you allergic to any medications? List: _____

_____

Reaction: Hives ☐ Swelling ☐ Itching ☐ Other: _____

PAST SURGICAL HISTORY: Please list below all your past operations with reason and date.

SOCIAL HISTORY:

Y ☐ N☐ Have you ever smoked?

If yes, # packs/day_____ # years smoked:_____

Y ☐ N☐ Are you still smoking?

If you have stopped smoking, when did you quit? _____

Y ☐ N☐ Do you drink alcohol?

If yes, please list type and quantity?

Y ☐ N☐ Do you use recreational drugs? What Type:

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

Children: Y ☐ N ☐ If yes, how many? _____

Current Occupation: _____

FAMILY HISTORY:

ILLNESS	RELATIVE	ILLNESS	RELATIVE
Diabetes		Breast Cancer	
Stroke		Colon Cancer	
Heart disease		Other Cancer:	
High Blood Pressure		Osteoporosis	

Patient Signature: _____ Date: _____