NEW PATIENT HISTORY

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DATE: ______________________________

REFERRING MD: ______________________________

PATIENT: ______________________________

REASON FOR YOUR VISIT: ______________________________

DOB: ____/ ____/ _____ Age: _____ Sex: M F

MEDICATION ALLERGIES: ______________________________

PHARMACY: ______________________________

DATE OF SYMPTON(S) ONSET: ______________________________

*****SELECT YES IF YOU HAVE EVER HAD*****

CARDIAC PROCEDURAL HISTORY

1) Heart Attack? . . . . YES NO

   If yes, when? ______________________

2) Coronary Angiogram or Balloon / stent procedure? . . . . . YES NO

   If yes, when? ______________________

3) Heart Surgery? . . . . YES NO

   If yes, type: ___________when: _________

4) Echocardiogram? *(ultrasound of heart)* YES NO

VASCULAR PROCEDURAL HISTORY

1) Pain in calves/thighs/buttocks when walking? YES NO

   How far do you walk prior to pain? ________________

2) Any sores on legs/feet? . . . . YES NO

3) Previous surgery on arteries? *(legs, abdomen, neck)* YES NO

4) Aneurysm? *(ballooning of artery)* . . . . YES NO

5) Carotid Doppler? *(ultrasound of arteries of neck)* . . YES NO

6) Arterial Doppler? *(leg circulation test)* . . . . YES NO