THE KIRKLIN CLINIC / AFFILIATED CLINICS

Vascular Surgery

Patient Information Sheet

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Date of Service: _____

Physician: _____

PLEASE PRINT:

Today's Date: _____

Patient Address: _____ Patient Phone #: ( ) _____

SS#: _____ City, State, Zip Code: _____

Emergency Contact: _____ Phone #: ( ) _____

Main Complaint: _____

_____

Other Illnesses You Now Have (if any): _____

_____

Referring MD: _____ Phone #: ( ) _____

Regular MD: _____ Phone #: ( ) _____

PAST HISTORY / REVIEW OF SYSTEMS (Please check if Yes) Not checking a box is considered a "NO" answer.

Heart trouble	☐	Anemia (Low Blood)	☐	High cholesterol	☐
Weight loss	☐	Lung trouble	☐	Leg swelling	☐
High blood pressure	☐	Asthma	☐	Muscle/joint aches	☐
Stroke	☐	Emphysema	☐	Diabetes	☐
Paralysis	☐	Chronic cough	☐	Numbness or tingle	☐
Severe headaches	☐	Thyroid trouble	☐	Female trouble	☐
Seizures	☐	Back ache (severe)	☐	Anticoagulant	☐
Ringing in ears	☐	Hepatitis	☐	(blood thinner treatment)	
Dizziness	☐	Stomach ulcers	☐	Blood transfusion	☐
Sudden loss of vision	☐	Kidney trouble	☐	Cancer	☐
Fainting spells	☐	Depression, crying, sad	☐		
Loss of appetite	☐	One sided weakness	☐		

FAMILY HISTORY (Including Aunts and Uncles) (Please check if Yes) Not checking a box is considered a "NO" answer.

HAS ANY BLOOD RELATIVE EVER HAD?		WHO?			
Seizure disorders	☐	_____	Mental illness	☐	_____
Cancer	☐	_____	Bleeding disorders	☐	_____
Diabetes	☐	_____	Blood clotting	☐	_____
Heart trouble	☐	_____	Kidney trouble	☐	_____
High blood pressure	☐	_____	Alzheimer's	☐	_____
Stroke	☐	_____	Aneurysms	☐	_____

SOCIAL HISTORY (Please check if Yes) Not checking a box is considered a "NO" answer.

HAVE YOU EVER?

Smoked or used other tobacco products? ☐

If yes, how many packs per day? _____

For how many years? _____

Quit Date: _____

Marital Status: Single Married Widowed Divorced

Number of Children (if any) _____ Grandchildren _____

Place of employment: _____

Drink alcoholic beverages? ☐

If yes, how many drinks per day? _____

For how many years? _____

Quit Date: _____

Church ☐

Sexually Active ☐

Homosexual Contact ☐

Recreational Drugs ☐

INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____ Group #: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Policy #: _____ Group #: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

PLEASE PRINT:

TODAY'S DATE: _____

MEDICATIONS: List milligrams and how often you take (be sure to include over the counter medications):

ALLERGIES: (include medications and other things)

LIST ANY OPERATIONS YOU HAVE HAD

Operation	Date	Surgeon	Hospital

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS LATELY: Not checking a box is considered a "NO" answer.

Chest pain, tightness or heaviness	☐	Pain when you urinate	☐
Heart racing	☐	Difficulty controlling your bladder	☐
Shortness of breath	☐	Cough	☐
Short of breath when laying down	☐	Fever	☐
Blood in your bowel	☐	Sore throat	☐
Black stools	☐	Rash or new moles	☐
Constipation	☐	Trouble swallowing	☐
Diarrhea	☐	Headache	☐
Stomach pain	☐	Sinus symptoms	☐
Overactive bladder	☐	More than usual swelling in legs	☐
Blood in urine	☐	Nausea	☐
Excessive urinating at night	☐	Falling or fainting	☐
Weakness in your arms	☐	Difficulty speaking	☐
Changes in your eyesight	☐	Seeing things that are not there	☐
Feeling cold	☐	New lumps in neck or under arms	☐

DESCRIBE ANY OTHER SYMPTOMS THAT YOU ARE HAVING:

SECTION BELOW FOR OFFICE USE ONLY

I have reviewed the above information:

Attending/Provider Signature

Date