YAKIMA VASCULAR ASSOCIATES

PATIENT NAME: _____ **Today's Date:**_____/_____/_____

Reason for appointment: _____ Referring Doctor: _____

List previous surgeries: _____

Other medical problems & hospital stays (not including pregnancies) _____

_____

Medications: _____

Allergies to Medications (please specify problem):

_____

Blood relatives with the following diseases (cancer ~ please indicate type of cancer ~ heart problems, blood pressure or diabetes):

Who may we contact outside of your home in case of an emergency?		
Name:	Relationship:	Phone Number:

Do you smoke: Y N If yes, how many packs per day? _____ Did you quit smoking? _____

Do you consume alcohol? Y N If yes, how many drinks per day? _____

Do you use or have you ever used street drugs? Y N If yes, which drugs? _____

Please check it you have/had problems related to the areas indicated:

	Yes	No
Constitutional		
Weight change		
Fevers		
Sweats		
Fatigue		
Eyes		
Glaucoma		
Cataracts		
Vision surgery		
Ears, Nose, Throat		
Loss of hearing		
Dizziness		
Nose bleeding		
Respiratory		
Pneumonia		
Asthma/Wheezing		
Shortness breath		
Sleep apnea		
Bronchitis		
Cardiovascular		
Chest pain		
Heart murmur		
Varicose veins		
Leg pain walking		
Transfusions		
Phlebitis/blood clot		
Rheumatic fever		

	Yes	No
Endocrine System		
Diabetes		
Thyroid problem		
Hormone treatment		
Breast		
Previous breast biopsies		
Breast lump(s)		
Discharge		
Pain		
Urinary System		
Urinary tract/bladder infections		
Kidney stones		
Prostrate problems		
Incontinence		
Skin		
Cancers		
Rashes		
Neurologic		
Stroke		
Seizures		
Head injury		

	Yes	No
Gastrointestinal		
Reflux		
Hepatitis		
Blood in stools		
Constipation		
Diarrhea		
Difficulty swallowing		
Jaundice		
Pain on bowel movement		
Incontinence		
Hernia?		
Musculoskeletal		
Osteoarthritis		
Rheumatoid		
Gout		
Infectious Disease		
Tuberculosis		
Hepatitis		
HIV/AIDS		
Psychiatric		
Depression		
Anxiety		
Following questions for women….		
Age at first period_____		
Still having periods		
Did you breastfeed		
Are you currently pregnant?		

The information provided in this form is true and complete to the best of my knowledge.

Patient signature: _____ Date:_____/_____/_____

Form reviewed by physician:_____ Date:_____/_____/_____