PATIENT INFORMATION SHEET

PATIENT NAME _____
ADDRESS _____
PHONE ( )_____-_____ CELL #( )_____-_____ DATE OF BIRTH ____-____-____
AGE _____ SS# ____ - ____ - _____ SEX ____M _____F SHOE SIZE _____
MARITAL STATUS _____ OCCUPATION _____EMPLOYER _____
FAMILY DOCTOR _____ EST DATE OF LAST VISIT _____
EMERGENCY CONTACT AND PHONE # _____( )_____-_____
PHARMACY _____ PHARMACY PHONE ( )_____-_____
HOW YOU HEARD OF OUR OFFICE _____

INSURANCE:

_____	_____	_____
Primary Insurance	Subscriber	Identification #
_____	_____	_____
Secondary Insurance	Subscriber	Identification #

CHIEF COMPLAINT TODAY _____ Date of onset: _____

MEDICAL HISTORY: Place a check mark to indicate if you have or have had any of the following:

___ AIDS/HIV	___ Foot/leg cramps	___ Nervous condition/Anxiety
___ Anemia	___ Gout	___ Neuromuscular disease
___ Angina	___ Headaches	___ Neuropathy
___ Arthritis (osteo)	___ Heart attack	___ Phlebitis
___ Arthritis (other, RA, Psoriatic)	___ Heart failure	___ Respiratory disease
___ Artificial joints	___ Heart valve replacement	___ Rheumatic fever
___ Asthma	___ Hemophilia	___ Shortness of breath
___ Bleeding disorder	___ Hepatitis	___ Sinus condition
___ Cancer	___ High blood pressure	___ Stomach ulcer
___ Chemical dependency	___ Hyperthyroidism	___ Stroke
___ Circulatory problems	___ Hypothyroidism	___ Venous disease
___ Diabetes (Insulin dependent)	___ Kidney disease	___ Venereal disease
___ Diabetes (Non-insulin dep.)	___ Liver disease	

Other _____

SURGICAL HISTORY: Please list your previous surgeries _____
_____

SOCIAL HISTORY:

Tobacco:	___ Current smoker	___ Previous smoker	___ Non smoker	
Alcohol:	___ Current/occasional	___ Current/frequent	___ Previous/Quit	___ Never
Recreational drugs:	___ Current/occasional	___ Current/frequent	___ Previous/quit	___ Never

FAMILY HISTORY: Please circle or check the following that apply:

Mother:	Alive / Deceased,	___Diabetes	___Heart Disease	___Cancer	___Hypertension	Other_____
Father:	Alive / Deceased,	___Diabetes	___Heart Disease	___Cancer	___Hypertension	Other_____
Sisters:	Alive / Deceased,	___Diabetes	___Heart Disease	___Cancer	___Hypertension	Other_____
Brothers:	Alive / Deceased,	___Diabetes	___Heart Disease	___Cancer	___Hypertension	Other_____

Physician Signature _____

REVIEW OF SYSTEMS: Please check if you have had any in the past, or _____NOTHING BELOW APPLIES

___ Fever
___ Night sweats
___ Significant weight gain
___ Significant weight loss

___ Eye symptoms

___ Difficulty hearing
___ Ear pain

___ Nosebleeds
___ Other nose problems

___ Sore throat
___ Bleeding gums
___ Oral ulcers
___ Teeth problems

___ Chest pain
___ Shortness of breath
___ Palpitations
___ Heart murmur

___ Coughing
___ Wheezing
___ Coughing up blood
___ Sleep apnea

___ Abdominal pain
___ Vomiting
___ Black stools
___ Frequent diarrhea
___ Vomiting blood
___ GERD

___ Difficulty urinating
___ Increased urinating
___ Blood in urine

___ Muscle aches
___ Muscle weakness
___ Joint pain
___ Back pain
___ Swelling in legs

___ Numbness in legs/feet
___ Loss of consciousness
___ Seizures
___ Dizziness
___ Headaches
___ Restless legs

___ Depression
___ Anxiety

___ Increased thirst
___ Hair loss
___ Cold intolerance

___ Excessive bruising
___ Excessive bleeding

___ Itching
___ Hives

___ Coughing
___ Wheezing

___ Rashes
___ Abnormal moles
___ Jaundice

ALLERGIES: Please check mark if you are allergic to any of the following:

___ Adhesive tape ___ Latex ___ Aspirin ___ Lidocaine ___ Novacaine
___ Codeine ___ Penicillin ___ Sulfa drugs ___ Cipro ___ Erythromycin
___ Iodine ___ Neosporin
Others _____

Have you had a Flu shot this year? _____Yes _____No If yes, estimate the date of last Flu shot _____

Have you ever had a Pneumonia shot? _____Yes ____No If yes, estimate date of last shot _____

Do you have or believe you have peripheral arterial disease(poor circulation)? _____YES _____NO
Do you have a vascular surgeon? ____YES ____NO Name of Vascular Surgeon_____

Diabetics:

How long have you been diabetic? _____ Do you experience tingling or numbness? ___ YES ___ NO
Do you check your blood sugar every day? ____YES ____NO What is your average blood sugar? _____
How often is your blood sugar level above 200? _____Never _____Seldom _____Often _____Always
Date of last visit to Doctor treating your Diabetes _____ What was your last HbA1c? _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give permission to Dr. Kissell and Dr. Latzanich to administer and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my condition.

_____ _____
Patient or responsible party Date

Physician Signature _____