VASCULAR & DIABETIC FOOT CENTER

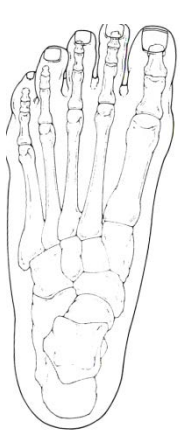
Patient Name: _____ DATE OF BIRTH: _____

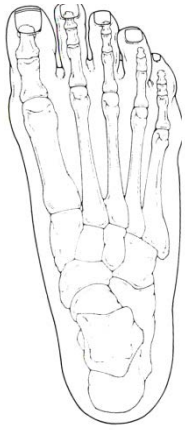
INITIAL PATIENT FORM

Reason for your visit: _____ Visit Date: _____

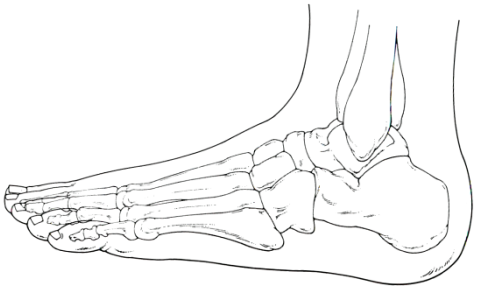
CIRCLE AREA(S) OF CONCERN:

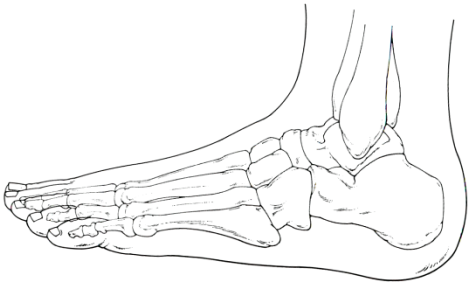
Left Right



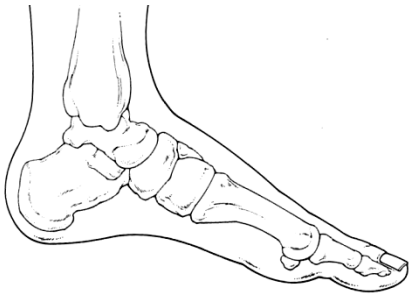


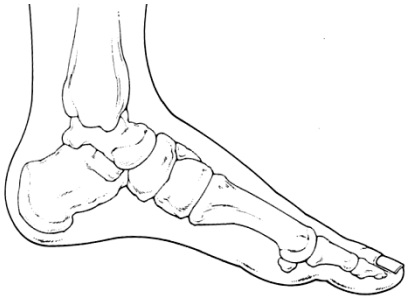
TOP/BOTTOM





OUTSIDE





INSIDE

Type of pain:

□ Sharp	□ Burning	□ Soreness	□ Tightness
□ Stabbing	□ Numbness	□ Aching	□ Pressure
□ Shooting	□ Tingling	□ Throbbing	
□ Pulling	□ Radiating	□ Cramping	
□ Tearing	□ Electric shocks	□ Pins & needles	

Pain Level (0-10): _____

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____

REFERING PHYSICIAN: _____

LIST OF TREATING PHYSICIANS (other than Primary Care and Referring):

Name	Specialty
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHARMACY Name: _____

Street Address: _____

City: _____ Phone: _____

HOME HEALTH AGENCY: Name: _____

Street Address: _____

City: _____ Phone: _____

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

CURRENT MEDICATIONS including over-the-counter & supplements: □ Provided attached list

Name of Medication	Dose	How often taken
Example: Metformin	500 mg	1 tablet, 2 times daily

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

PAST MEDICAL HISTORY (e.g. diabetes mellitus, hypertension, hypercholesterolemia, etc.):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PAST SURGICAL HISTORY (e.g. appendectomy, tonsillectomy, etc.) including date(s)**:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DRUG ALLERGIES / REACTIONS (name & reaction): □ No Known Drug Allergies

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY (not personal) HISTORY: **(Mother, Father, Sibling, etc.)** **□ Adopted – No known family history**

□ Cancer _____ □ Arterial Disease_____ □ Seizures _____

□ Diabetes _____ □ Kidney Disease _____ □ Stroke _____

□ Heart Disease _____ □ Lung Disease _____ □ Heart Attack _____

□ Hypertension _____ □ Mental Illness _____ □ Other _____

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

SOCIAL HISTORY:

Tobacco Use:

□ Current every day smoker: *Year started*: _____ □ *Cigarettes:* ____ *per day* □ *Cigars:* _____ *per day*

□ Former Smoker: *Year quit*: _____

□ Never Smoker

□ Smokeless Tobacco: *Year started*: _____ *Type* _____ *Amount per day* _____

□ Nicotine gum or patch: *Amount per day* _____

□ Electronic Cigarettes: *Year started*: _____ *Amount per day* _____

Caffeine Use: □ *Yes* □ *No* *Type* _____ *Cups per day* _____

Alcohol Use: □ *Yes* □ *No* *Type* _____ *Amount per day* _____

Substance Abuse: □ *Yes* □ *No* *Substance (e.g. cocaine, marijuana)* _____

Illicit Drug Use: □ *Yes* □ *No* *Drug (e.g. OxyContin, Hydrocodone)* _____

Marital Status: _____ # Children: _____ Occupation: _____

Lives in (e.g. home, apartment): _____ Lives with (e.g. no one, spouse): _____

Cultural, Religious, or Language Concerns: _____

ADVANCED DIRECTIVES AND INSTRUCTIONS:

Advanced Directives: _____ □ Do not resuscitate

Durable power of attorney for healthcare: _____

FALL RISK ASESSMENT:

History of Falling: □ *Yes* □ *No*

Secondary Diagnosis (have more than 1 medical diagnosis): □ *Yes* □ *No*

Aids for walking: □ *none/wheelchair/bed rest* □ *crutches/cane/walker* □ *furniture (use for support)*

IV or IV Access: □ *Yes* □ *No* Gait: □ *normal / wheelchair / bed rest* □ *weak* □ *impaired*

Mental Status: □ *oriented/understand own ability* □ *overestimate or forget limitations*

Have you experienced or more falls without injury within past year: □ *Yes* □ *No*

Have you experienced any fall with injury within past year: □ *Yes* □ *No*

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

Constitutional: □ **None**
□ *chills*
□ *fatigue*
□ *fever*
□ *loss of appetite*
□ *marked weight change*
□ *night sweats*
□ *weight gain*
□ *unintentional weight loss*
□ *weakness*
□ *other:* _____

Eyes: □ **None**
□ *blurred vision*
□ *discharge/drainage*
□ *double vision/spots/flashing lights*
□ *dry eyes*
□ *excessive tearing*
□ *eye pain*
□ *glasses/ contacts*
□ *partial/complete blindness*
□ *sensitivity to light*
□ *vision changes*
□ *other:*

Ears/Nose/Mouth/Throat: □ **None**
□ *bleeding gums*
□ *current infection*
□ *dental problems*
□ *difficulty clearing ears*
□ *bad breath*
□ *hearing loss/aid*
□ *hoarseness*
□ *ear pain*
□ *frequent colds*
□ *loss of smell*
□ *loss of taste*
□ *nasal congestion*
□ *nose bleeds*
□ *earache*
□ *painful/swollen lymph nodes*
□ *post nasal drip*
□ *sore throat*
□ *other:* _____

Cardiovascular: □ **None**
□ *chest pain*
□ *profuse sweating*
□ *difficulty breathing on exertion*
□ *edema*
□ *leg pain when walking*
□ *leg resting pain*
□ *leg swelling*
□ *difficulty breathing laying down*
□ *palpitations*
□ *fainting*
□ *other:*

Gastrointestinal: □ **None**
□ *acid reflux*
□ *bloody stools*
□ *bowel incontinence*
□ *change in bowel habits*
□ *constipation*
□ *diarrhea*
□ *difficulty swallowing*
□ *hemorrhoids*
□ *indigestion*
□ *jaundice*
□ *loss of appetite*
□ *nausea / vomiting*
□ *rectal bleeding*
□ *stomach/abdominal pain*
□ *vomiting of blood*
□ *other:* _____

Genitourinary: □ **None**
□ *abnormal vaginal bleeding*
□ *bladder spasm*
□ *blood in urine*
□ *decreased force in stream*
□ *urinary infrequency*
□ *voiding multiple times at night*
□ *painful urination*
□ *pregnant*
□ *urinary incontinence*
□ *other:* _____

Integumentary: □ **None**
□ *change in hair, skin, nails*
□ *skin dryness*
□ *calluses/corns*
□ *change in mole appearance*
□ *itching*
□ *lesions*
□ *lumps*
□ *prone to skin tears*
□ *rash*
□ *skin allergies*
□ *sun sensitivity*
□ *other:* _____

Endocrine: □ **None**
□ *cold intolerance*
□ *heat intolerance*
□ *excessive thirst*
□ *excessive hunger*
□ *excessive urination*
□ *other:* _____

Musculoskeletal: □ **None**
□ *assistive devices:* _____
□ *backache*
□ *contractures*
□ *decreased activity*
□ *deformities*
□ *joint pain*
□ *joint swelling*
□ *muscle pain*
□ *muscle wasting*
□ *muscle weakness*
□ *other:* _____

Neurologic: □ **None**
□ *abnormal gait*
□ *dizziness*
□ *headaches*
□ *loss of sensation to feet*
□ *memory loss*
□ *numbness*
□ *one-sided weakness*
□ *paralysis*
□ *seizures*
□ *spasms*
□ *tingling*
□ *tremors*
□ *weakness*
□ *other:* _____

Hematologic/Lymphatic: □ **None**
□ *bruising easily*
□ *bleeding/clotting disorders*
□ *bleeding tendency*
□ *blood transfusions*
□ *enlarged lymph nodes*
□ *swelling*
□ *swollen glands*
□ *other:* _____

Allergic/Immunologic: □ **None**
□ *frequent rashes*
□ *hay fever*
□ *hives*
□ *runny nose*
□ *recurrent fevers*
□ *other:* _____

Psychiatric: □ **None**
□ *anxiety*
□ *claustrophobia*
□ *insomnia*
□ *nervousness/tension*
□ *restraints*
□ *suicidal*
□ *memory loss*
□ *depression*
□ *other:*