

VASCULAR SPECIALISTS OF MOBILE, PC

NAME _____ DATE _____ CHART # _____

AGE _____ SEX _____ RACE _____ OCCUPATION _____

REFERRING MD / PHONE NUMBER _____

PRIMARY OR FAMILY MD / PHONE NUMBER _____

REASON YOU CAME TO SEE THE DOCTOR _____

PAST MEDICAL HISTORY / HOSPITALIZATIONS, DATES AND REASONS

SURGERIES

MEDICATONS

DRUG ALLERGIES _____ DO YOU SMOKE NOW ? YES NO

NUMBER OF PACKS PER DAY _____

ARE YOU DIABETIC ? YES NO NUMBER OF YEARS SMOKED _____

ARE YOU HYPERTENSIVE ? YES NO STOPPED SMOKING WHEN ? _____

REVIEW OF SYSTEMS: DO YOU HAVE ANY OF THE FOLLOWING ?

	YES	NO	EXPLAIN
PRIOR STROKES _____			
DIZZINESS/BLACKOUTS _____			
BLIND SPELLS _____			
EAR/NOSE/THROAT _____			
THYROID DISORDER _____			
LUNG CONDITION _____			
HEART _____			
STOMACH / LIVER _____			
GALLBLADDER / COLON _____			
BONE / JOINT PROBLEMS _____			
ARMS _____			

	YES	NO	EXPLAIN
PROSTATE (MEN)			
BLEEDING DISORDERS			
OTHER PROBLEMS			
LEGS / DIFFICULTY WALKING / SWELLING			

FAMILY HISTORY

PLEASE LIST FAMILY MEDICAL PROBLEMS _____

ALCOHOL CONSUMPTION _____

*****DO NOT WRITE IN AREA BELOW*****

HISTORY/PHYSICAL B/P _____ RT _____ LT _____ WEIGHT _____

NURSES' NOTES

PHYSICAL EXAM

PULSE STATUS	CAROTID	RADIAL	ABD	FEM	POP	DP	PT
LEFT							
RIGHT							

NAME _____

CPT # _____

CHART # _____

TODAY _____

DATE _____

RETURN _____