WEST COUNTY SURGICAL SPECIALISTS, INC.

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PATIENT'S FULL NAME ____ **M/F**_____
Last First Middle
ADDRESS ____**Apt#** ____________

CITY________________________________ **STATE** _________ **ZIP**____________

HOME PHONE ( )_________________________**CELL #** __________________________
DATE OF BIRTH___________________ **AGE**________

SOCIAL SEC. #______________________

EMPLOYER _______________________________ **ADDRESS** _____________________________

WORK PHONE ______________ **EXT.** ______ **MARITAL STATUS M__S__W__D__**

SPOUSE'S NAME________________ **DATE OF BIRTH** _____________ **AGE** ________

EMPLOYER ___________________________ **ADDRESS** ________________________________

SPOUSE'S SOC. SEC. # _____________________ **WORK PHONE** _______________________
CELL # ___________________ **ALLERGIES TO MEDICATIONS:**_______________________

IF PATIENT IS A MINOR, RESPONSIBLE PARTY'S NAME ___________________________
ADDRESS____________________________ **PHONE** __________________________________
EMPLOYER'S ADDRESS ____

INSURANCE INFORMATION
Company **Policy#** **Group#** **Insured**
1.____

2.____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?___________________________
Relationship ______________________________ **Phone #.**______________________________
____

Is this visit due to an injury? Y/N Is this a work-related injury? Y/N If yes date of injury ___________
____

WHOM MAY WE THANK FOR REFFERRING YOU TO US? ___________________________

I hereby authorize my insurance company to pay all benefits directly to West County Surgical Specialists, Inc. I understand that execution of this assignment in no way relieves me of my financial responsibility, and any unpaid claims resulting in collection procedures may have fees assessed with them.

DATE: ________________ **SIGNATURE:** ____

I authorize West County Surgical Specialists, Inc. to release medical information pertaining to the patient's treatment to my insurance company, and/or attorney, and/ or Workmen's Compensation carrier as needed to process claims.
In addition I wish to authorize the following person ___________________ relationship _____________________
To discuss information regarding my condition and medical information.

DATE: ________________ **SIGNATURE:** ____

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

Referring Physician: ______________________________________

Current History:

1. Symptom: What specifically brings you to the doctor today?
____
____

2. Duration: When did this problem start? _________________________________

If you are experiencing any pain, how long does it last?_________

3. Location: Where exactly is the pain or problem located, including which side of the body?
____

Left side______ Right side______ both sides______

4. Severity: On a scale of zero to ten(10 being the worst pain), how would you rate your pain? _______________

5. Quality: Describe exactly what the pain feels like (sharp, dull, constant, stabbing, etc...)
____

6. Timing: When exactly does the pain occur (rest, activity, while sleeping, etc.)?
____
____

7. Context: Is this pain related to:

___Activities ___Exercise ___Rest ___Meals

8. Modifying Factors: Does anything seem to help the problem such s rest or medication? ____

9. Associated Signs/Symptoms: Are you having any other problems because of this condition?
____
____

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

PAST MEDICAL HISTORY

ALLERGIES

Are you allergic to any medications (s)?
___ Yes (please list) ___ No

Are you allergic to Latex?
___ Yes ___No   Reaction: ________

Medication **Reaction**

1.____
2.____
3.____
4. ____
5. ____
6. ____
7. ____
8. ____

Medications you are currently taking: Include aspirin and over-the-counter medicine.

Drug Name Dose How Often

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10.____

Past Hospitalizations and Operations:

Reason Year

1. ____
2. ____
3. ____
4. ____
5. ____

Do you have any implanted medical devices?

___Pacemaker ___Defibrillator ___Orthopedic hardware/total joints

___Portacath ___Other (please explain): _________________________

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

Social history:
Height: ___________________
Current Weight: ____________
Do you smoke? : ____________
If yes pack per day: ____________ for __________ years.
If you smoked in the past, when did you quit? ________________
Do you consume alcohol? ______ How much? _______________ how often? _______
Recreational/street drugs? ______ What type? _______ How often? ________________
Your last flu shot _________ Pneumovax ____________ Tetanus ___________
Do you wear: __________ Glasses _________ Contacts __________ Dentures __________
Hearing aids __________
Do you exercise? __________ What type ? _______ How often? __________

Family Health History: Please indicate relatives who have or had this disease.
Heart disease: ____
High Blood pressure: ____
Stroke: ____
Diabetes: ____
Bleeding disorders: ____
Kidney disease: ____
Cancer (type): ____
High cholesterol: ____

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS

Recent weight loss/gain	N	Y ___________________________________
Fever	N	Y ___________________________________
Headaches	N	Y ___________________________________
Fatigue	N	Y ___________________________________
Night Sweats	N	Y ___________________________________

Other
____
____

INTEGUMENTARY (SKIN)

Rash or itching	N	Y ___________________________________
Change in skin color	N	Y ___________________________________
Change in hair or nails	N	Y ___________________________________

* If yes please explain

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing	N	Y ____________________
Earaches or drainage	N	Y ____________________
Chronic sinus problem	N	Y ____________________
Nose bleeds	N	Y ____________________
Mouth sores	N	Y ____________________
Bleeding gums	N	Y ____________________
Sore throat/voice change	N	Y ____________________
Swollen glands in neck	N	Y ____________________
Glaucoma	N	Y ____________________
Cataract	N	Y ____________________
Loss Vision	N	Y ____________________

*If yes explain

RESPIRATORY

Chronic or frequent coughs	N	Y ____________________
Coughing up blood	N	Y ____________________
Shortness of breath	N	Y ____________________
Asthma or wheezing	N	Y ____________________
Emphysema/COPD	N	Y ____________________
Use Oxygen at Home	N	Y ____________________
Sleep Apnea	N	Y ____________________
Chronic Bronchitis	N	Y ____________________
Pneumonia	N	Y ____________________

*If yes please explain

CARDIOVASCULAR

Heart Attack	N	Y ____________________
Chest pain/Angina	N	Y ____________________
Cardiac Stents	N	Y ____________________
Irregular heart beat	N	Y ____________________
Congestive Heart Failure	N	Y ____________________
Murmur	N	Y ____________________
High blood pressure	N	Y ____________________
Palpitations	N	Y ____________________
Mitral Valve Prolapse	N	Y ____________________
Swelling of the feet	N	Y ____________________

* If yes please explain

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

GASTROINTESTINAL

Loss of appetite	N	Y ____________________
Change in bowel movements	N	Y ____________________
Nausea or vomiting	N	Y ____________________
Painful bowel movements	N	Y ____________________
Constipation	N	Y ____________________
Diarrhea	N	Y ____________________
Rectal bleeding/blood in stool	N	Y ____________________
Abdominal Pain	N	Y ____________________
Peptic Ulcer (stomach)	N	Y ____________________
Heartburn/Acid Reflux	N	Y ____________________
Gallbladder problems	N	Y ____________________
Colon Polyps	N	Y ____________________
Date of Last Colonoscopy	N	Y Date ________________
Last Upper Endoscopy	N	Y____________________

GENITOURINARY

Frequent Urination	N	Y ____________________
Burning or painful urination	N	Y ____________________
Blood in Urine	N	Y ____________________
Change in force/strain to urinate	N	Y ____________________
Incontinence	N	Y ____________________
Kidney Stones	N	Y ____________________
Male-testicular pain	N	Y ____________________
Female- last menstrual period	N	Y ____________________
Enlarged Prostate	N	Y ____________________
Prostate Cancer	N	Y ____________________

MUSCULOSKELETAL

Difficulty walking	N	Y ________After how many blocks ______
Cramps in calves or thighs walking	N	Y ____________________
Pain that wakes you from sleep	N	Y ____________________
Joint stiffness or swelling	N	Y ____________________
Weakness of muscles or joints	N	Y ____________________
Cold extremities	N	Y ____________________
Numbness/Tingling of legs	N	Y ____________________
Numbness/Tingling of arms	N	Y ____________________

NEUROLOGIC

Stroke	N	Y ____________________
Mini Strokes/TIA's	N	Y ____________________
Paralysis	N	Y ____________________
Tremors	N	Y ____________________
Seizures	N	Y ____________________
Loss of Memory or Dementia	N	Y ____________________
Headaches	N	Y ____________________
Dizziness	N	Y ____________________

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

PSYCHIATRIC

Depression	N	Y ________________
Anxiety	N	Y ________________
Panic Attacks	N	Y ________________
ENDOCRINE		
Diabetes	N	Y ________________
Insulin	N	Y ________________
Oral meds only	N	Y ________________
Thyroid Disease	N	Y ________________
Cold Intolerance	N	Y ________________
Heat Intolerance	N	Y ________________

HEMATOLOGIC

Bleeding Tendency	N	Y ________________
Taking Blood Thinners	N	Y __________Type __________
Reason ________________		
Clotting Problems	N	Y ________________
Anemia	N	Y ________________
Phlebitis	N	Y ________________

Have you had any recent testing (within the last 6 months)?

Type When Where

Blood Work: ________________
EKG: ________________
Echocardiogram (heart ultrasound) : ________________
X-rays/CT scans:
____
MRI or MRA: ________________
Carotid (neck) Doppler/ultrasound: ________________
Leg Doppler/ultrasound: ________________