VASCULAR AND INTERVENTIONAL SPECIALISTS OF ORANGE COUNTY, INC.

VASCULAR SURGERY AND ENDOVASCULAR SURGERY

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ENDOVASCULAR AND INTERVENTIONAL RADIOLOGY

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Dear Valued Patient,

Thank you for selecting VISOC to provide medical care for you and your family.

To ensure that your visit with us is as smooth and timely as possible, please bring the following items with you. This will help to avoid any cancellation or rescheduling of your appointment.

1. Medical Questionnaire (enclosed) – this form **must be** completed in full prior to check-in, if not, then your appointment may be significantly delayed or cancelled.
2. Your insurance card (s)
3. Pertinent test or x-ray results that have been done at another facility, including but not limited to the actual MRI, CT scans or angiogram films (copies are acceptable)
    - Please check-out/pick-up outside films and bring them with you to your appointment
4. Authorization for your visit (as applicable)
5. Co-payment (as applicable)

If you are having a vascular lab study or having vein injections, you may want to wear or change into a short sleeve shirt/top, shorts or other loose fitting clothing for that portion of your office visit.

Should there be a need to cancel or to reschedule your current appointment, we ask that you kindly give us at least 24 hour notice. Again, thank you for selecting our office for your vascular surgery and interventional radiology needs.

Sincerely,

Vascular and Interventional Specialists of Orange County

VASCULAR SURGERY QUESTIONAIRE

NAME _____ **AGE:** _____ **D.O.B.** _____
PRIMARY CARE PHYSICIAN: _____
WHO REFERRED YOU TO US? _____

REASON FOR VISIT (please circle all that apply):

1) Aortic aneurysm yes
2) Carotid artery disease yes
3) Difficulty walking yes
4) Kidney failure/hemodialysis yes
5) Leg swelling yes
6) Nonhealing foot/toe ulcer yes
7) Toe/foot gangrene yes
8) Varicose veins yes
9) Other _____

PAST MEDICAL HISTORY (please circle if yes):

1) Coronary artery disease yes Name of cardiologist?_____
2) Heart attack yes When? _____
3) Stroke/TIA yes When?_____
4) High blood pressure yes What is your average Bp? _____/_____
5) Diabetes mellitus yes How long? _____ What type?_____
6) Problems with blood clotting yes Describe: _____
7) Clots in veins yes When and where? _____
8) Kidney failure yes Name of kidney doctor?_____
9) Gastrointestinal Disease: yes Specify:_____
10) Lung Disease yes Specify:_____
11) Thyroid Disease yes Specify:_____
12) Elevated cholesterol/lipids yes Specify if known. _____
13) Smoking yes How much? _____
14) Do you drink alcohol? yes How much? _____

MEDICATIONS (dosage and frequency):

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

ALLERGIES: _____

PAST SURGICAL PROCEDURES with date: _____
_____ _____
_____ _____
_____ _____

NAME_____

FAMILY HISTORY

1. Parent	Age	Condition or Illness	If deceased, age at death
Mother			
Father			

2. Have any of your other relatives (brothers, sisters, or children) had any of the following?

a) Heart trouble	Yes	No
b) Stroke	Yes	No
c) High blood pressure	Yes	No
d) Diabetes	Yes	No
e) Bleeding disorders	Yes	No
f) Aneurysm	Yes	No
g) Varicose Veins	Yes	No

REVIEW OF SYSTEMS

1. HEAD & EYES

a) Are you troubled by unusual or severe headaches?	Yes	No
b) Have you ever temporarily lost sight in one eye?	Yes	No
c) Have you been told that you have glaucoma	Yes	No

2. RESPIRATORY

a) Do you get short of breath climbing one flight of stairs?	Yes	No
b) Do you have asthma or wheezing?	Yes	No
c) Do you have tuberculosis?	Yes	No
d) Do you have shortness of breath at rest?	Yes	No
e) Do you have emphysema?	Yes	No

3. CARDIAC

a) Do you have any known heart disease?	Yes	No
b) Do you get chest pain?	Yes	No
c) Do you have to sleep with your head elevated on several pillows because of shortness of breath?	Yes	No
d) Do you ever wake from sleep with marked shortness of breath?	Yes	No
e) Do you ever feel your heart racing or pounding for no apparent reason?	Yes	No

4. GASTROINTESTINAL

a) Do you have frequent heartburn or indigestion?	Yes	No
b) Do you have any history of stomach or duodenal ulcer?	Yes	No

c) Have you ever had yellow jaundice or hepatitis? Type: A____ B____ C____ Yes No
d) Do you have bright red blood with bowel movements? Yes No

NAME_____

5. GENITOURINARY

a) Do you currently have a bladder or kidney infection? Yes No
b) Do you have difficulty urinating? Yes No
c) Have you recently had any blood in your urine? Yes No
d) Do you awake at night to urinate? Yes No

6. HEMATOLOGIC

a) Are you anemic? Yes No
b) Have you ever had blood transfusions? Yes No
c) Do you bleed readily? Yes No

7. MUSCULOSKELETAL

a) Have you had any fractured or broken bones? Yes No
(If "Yes", please list and give dates.)

b) Are you troubled by low back pain or back strain? Yes No

c) Is there any history of pain, stiffness, or swelling of joints? Yes No

8) OBSTETRICS AND GYNECOLOGIC *(For females only)*

a) Are you currently pregnant? Yes No
b) What is the date of your last menstrual period? _____

9) PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU WOULD LIKE ME TO KNOW ABOUT.

*****Please fill out the final page if you are being seen for varicose veins or any other venous problem – thank you.

NAME_____

Current Venous History

SYMPTOMS (Please check all that apply)

Left	Right		Left	Right	
□	□	Aching or pain	□	□	Throbbing
□	□	Leg cramps	□	□	Itching/Burning
□	□	Swelling	□	□	Heaviness
□	□	Tiredness/Fatigue	□	□	Restless Legs

Please indicate the duration of the above symptoms: □ 1-3 months □ 4-6 months □ 6-12 months □ >12 months

Have any of the above symptoms resulted in impaired mobility or inability to perform your daily activities? Y/N

Do you wear support hose? Y/N If yes, are they prescription? Y/N
How many years have you been wearing support hose?
Do they help reduce symptoms? Y/N

Does standing aggravate your symptoms? Y/N
What helps to decrease your symptoms?
What makes your symptoms worse?

WOMEN: Do symptoms increase before/during menstruation? Y/N
Are you pregnant or actively trying to get pregnant? Y/N
Are you breast feeding? Y/N

VENOUS MEDICAL HISTORY

History of:
□ Vein Surgery If yes, year _____ and MD name
□ Vein Injections If yes, year and MD name
□ Vein Laser or RFA Treatment If yes, year and MD name
□ Blood Clots (Phlebitis)? Y/N
□ Leg Ulcers or Spontaneous Bleeding? Y/N
□ Skin Discoloration? Y/N
□ Other Vein Treatment or Leg Injury:
□ Hepatitis □ HIV □ AIDS

□ Pregnancies: Number: □ Deliveries: Number

Birth Years:

What made you decide to seek treatment at this time?