

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)
 - o 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

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 |

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.

Current Venous History

SYMPTOMS (Please check all that apply)

- | Left | Right | Left | Right |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Aching or Pain | | Throbbing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Leg cramps | | Itching/Burning |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Swelling | | Heaviness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 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 Skin Discoloration

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? _____