MARYLAND VASCULAR SPECIALISTS
Compassionate. Innovative. Trusted.

INITIAL CONSULT / FOLLOW UP

Name: _____ Date: _____

Reason For Visit: _____

Do you have any allergies to medications or dyes? If yes, please list them below.

_____

_____

Are you currently taking: Plavix Yes / No Coumadin Yes / No Xarelto Yes / No

Please list your current medications below:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Name and Address of Pharmacy: _____

_____

Medical History:

Do you have now or have you ever had: (check all that apply)

____ Anemia
____ Aneurysm
____ A-Fib
____ Back Problems
____ DVT (Blood Clots)
____ Cancer
____ Coronary Artery Disease
____ Diabetes
____ High Blood Pressure
____ Heart Attack
____ Kidney Disease
____ Stroke / TIA
____ Vascular Disease
____ GERD
____ Varicose Veins
____ High Cholesterol

Surgeries (within the past year): _____

_____

Have you had any of the following ultrasounds recently? (check all that apply)

____ Carotid (neck) ____ Abdominal ____ Legs

** TURN OVER TO CONTINUE **

Have you ever had balloon procedures or stents in your heart, kidneys, abdomen, legs or arms? YES / NO

If yes, What is the date and type of procedure? _____

_____

Do you smoke? Yes / No If Yes, How often? _____ Previous Smoker? Yes / No

Do you have a Pacemaker? Yes / No

Are you currently on Dialysis? Yes / No Dialysis Days _____

Name and Number of Center: _____

Do you have any painful sores or ulcers? Yes / No

Are you a patient at a Wound Care Center? Yes / No

If yes, where? _____

Have you recently been hospitalized?

If yes, where? _____

When you walk do you experience aching, cramping or pain in you legs?
If YES, when do you feel pain?

_____ After walking 1 block _____ After walking 100 yards

_____ Climbing a flight of stairs _____ Walking at an increased speed

Do any of your relatives have any of the following? (Check which one(s))

	Yes	No	Relationship
Heart Disease:	❑	❑	_____
Vascular Disease:	❑	❑	_____
Diabetes:	❑	❑	_____
Aneurysms:	❑	❑	_____
None:	❑	❑	_____

HEIGHT:_____ WEIGHT:_____

My signature verifies that the information provided is correct to the best of my knowledge. (If completed by someone other than the patient, please indicate your name and relationship to the patient.)

Patient _____

Signature: _____ Date: _____

B / P:_____ / _____