NEW PATIENT VISIT

Lake Washington Vascular, 1135 116th Ave NE, Suite 305, Bellevue, WA 98004 | Phone: (425)453-1772 | Fax: (425) 453-0603

Please fill in ALL the information as accurately as possible. The information you provide will help create your patient chart. All answers are confidential.

Patient Preferred Name__________________________ Today's Date______________

Reason for today's visit____

Please list your height and weight: Height:________ Weight:________

Preferred Pharmacy Name and Location (City and Zip Code):____________________ Phone Number______________

Do you , or have you ever had any of the following medical problems? (check all that apply)

Arterial Disease

- ☐ High Blood Pressure
- ☐ Coronary Disease
- ☐ Stent ☐ Angioplasty ☐ Heart Bypass Check
- ☐ Heart Attack, when______________
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Pacemaker or Defibrillator
- ☐ Aneurysm, where______________
- ☐ Peripheral Artery Disease
- ☐ Blood Clot, where______________
- ☐ High Cholesterol
- ☐ Other______________

Venous Disease

- ☐ Pulmonary Embolism
- ☐ Varicose Veins ☐ Left ☐ Right
- ☐ Spider Veins ☐ Left ☐ Right
- ☐ Deep Vein Thrombosis
- ☐ Clotting Disorder
- ☐ Other______________

Respiritory

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea ☐ Using CPAP
- ☐ Other______________

Gastrointestinal

- ☐ Acid Reflux (GERD)
- ☐ Ulcers
- ☐ Liver Disease/Hepatitis
- ☐ Hemorrhoids
- ☐ Other______________

Musculoskeletal

- ☐ Back Problems
- ☐ Neck Problems
- ☐ Arthritis
- ☐ Treatment for Chronic Pain
- ☐ Other______________

Skin

- ☐ Skin Ulcers, where______________
- ☐ Dermatitis
- ☐ Other______________

Neurological

- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA/mini-stroke
- ☐ Migraine Headaches
- ☐ Other______________

Genitourinary

- ☐ Kidney Failure
- ☐ Are you on dialysis, what type ☐ Hemodialysis ☐ Peritoneal
- ☐ Enlarged Prostate
- ☐ Impotence (Erectile Dysfunction)
- ☐ Other______________

Endocrine/Other

- ☐ Cancer, type______________
  Treatment______________
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Fibromyalgia
- ☐ Other______________

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Other______________

Surgical History

Please indicate to the best of your ability, any surgical procedures you have had in the past. Please include the location, surgeon, and month and year the surgery occurred. If you have had more than three, please inform your medical assistant.

Surgery	Location	Surgeon	Date

☐ **I HAVE NEVER HAD SURGERY**

Family History

In the section below, we ask you to share information about your family's health. Please indicate which family members have had any health issues by checking the appropriate boxes. If you're mentioning other relatives, such as a grandparent, please specify if they are from your mom's side (maternal) or dad's side (paternal) of the family. Don't worry about your own health history for now; we'll cover that on the next page.

Health Issue	Mother	Father	Other Relative
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Blood Clots	☐	☐	
Varicose Veins	☐	☐	
Aneurysm	☐	☐	

☐ **NONE OF THESE HEALTH ISSUES ARE APPLICABLE TO MY FAMILY**

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PATIENT NAME & ID #

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Please fill in ALL the information as accurately as possible. The information you provide will help create your patient chart. All answers are confidential.

Social History

Tobacco: ☐ Never ☐ Now ☐ Past
Type: ☐ Cigarettes ☐ Cigars ☐ Smokeless Tobacco ☐ E-Cig/Vape
How long have you been smoking?________________
How many packs per day?________________
If still smoking, do you have plans to quit? ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasionally ☐ Daily ☐ Weekly
Number of dinks per day________ or week ________
Do you use any other substances? ☐ Yes ☐ No
If so, please list____

Living Situation:
☐ Alone ☐ Assisted Living ☐ Family Member
☐ Spouse/Significant Other Name________________
☐ Other________________
Do you have any children? ☐ Yes ☐ No
How many?________
Occupation________________________
Employer________________________
Are you currently pregnant? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No

Medications

To Fill out the medication section accurately, please look at the labels on your prescription bottles or contact your pharmacy or doctor if you need more information. Remember to list every type of medication you're taking. **This includes vitamins, herbal remedies, supplements, birth control, inhalers, and pain relievers.**

Name of Medication	Dosage	When do you take it?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

☐ **I DO NOT TAKE ANY MEDICATIONS**

Allergies

I am allergic to:	Reaction

☐ **I HAVE NOI KNOWN ALLERGIES**

Review of Systems

*Are you **CURRENTLY** experiencing any of the following symptoms?*

Cardiovascular
☐ Chest Pain/Angina
☐ Heart Palpitations

Respiratory
☐ Shortness of Breath
☐ Cough
☐ Wheezing

Gastrointestinal
☐ Pain w/ Eating
☐ Nausea/Vomiting
☐ Blood in Stool

Muskuloskeletal
☐ Back or Neck Pain
☐ Joint Pain, where____________________
☐ Muscle Pain, where____________________

Pelvic
☐ Frequent Urination
☐ Pain w/ Intercourse
☐ Chronic Pelvis Pain
☐ Vulvar Varicose Veins

Vascular
☐ Pain w/ Walking
Are your legs:
☐ Heavy
☐ Aching
☐ Swollen
☐ Throbbing
☐ Itching

Neurological
☐ Transient Change in Speech
☐ Transient Weakness in Arm or Leg
☐ Sudden Vision Change

Arterial
☐ Pain at Night
☐ Pain w/ Walking, where____________________
☐ Wounds, where____________________
☐ Diabetic Ulcers

LAKE WASHINGTON VASCULAR

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