

PATIENT INFORMATION FORM

Name (last, first, middle): _____

DOB: ____/____/____ Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

preferred call method

preferred call method

Email Address: _____ DO NOT enroll me in the online health portal

Gender: Male / Female Marital Status: Single / Married / Widowed / Divorced / Separated

Occupation: _____ Work Status: Employed / Unemployed / Retired / Disabled

Race (please check one)

- Not specified / Other
- Native American or Alaskan Native
- Asian
- Black or African American
- Hawaiian Native or Other Pacific Islander
- White

Ethnicity (please check one)

- Not specified / Other
- Hispanic or Latino
- Not Hispanic or Latino

Preferred Language: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Reason for Today's Visit: _____

Emergency Contact

Name (last, first, middle): _____ Relationship: _____

Phone Number: _____ home / cell Email Address: _____

Name (last, first, middle): _____ Relationship: _____

Phone Number: _____ home / cell Email Address: _____

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

Communication Preferences

Endovascular Consultants of Colorado contacts patients for a variety of reasons, including appointment reminders and providing test results. Please let us know how you prefer us to communicate with you.

Please DO NOT contact me at the following (check all that apply):

Cell Phone

- Reminder Calls
- Voicemail
- Text Reminders - SMS (standard charges may apply)

Home Phone

- Reminder Calls
- Voicemail

Patient Portal

- Appointment Reminders
- General Notifications

Patient Consent to Release Protected Health Information

Authorized by:

Patient _____ Legal Guardian/POA: _____

Disclose my Protected Health Information to:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

This authorization is in force until:

___ It is cancelled in writing

___ Other: _____

Patient Name (Please Print)

Date

Patient/Guardian Signature

Relationship to Patient

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

Insurance Information

PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AT EVERY VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Secondary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Tertiary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

 Patient Name (Please Print)

 Date

 Patient/Guardian Signature

 Relationship to Patient

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

Patient Name: _____ DOB: _____

Surgical History

Surgery	Year	Location/Facility

Prior Anesthesia Complications?

No Yes; Please explain: _____

Personal Medical History

Please check any of the following health problems you have had or have now:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Stroke or Mini Stroke	<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Pain in legs with walking	<input type="checkbox"/> Stomach Reflux/Heartburn	<input type="checkbox"/> Aneurysm Location: _____
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Problems/Failure	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Diabetes Type: _____
<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pacemaker/ICD	<input type="checkbox"/> Bleeding or Clotting Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Varicose Veins/Vein Stripping	<input type="checkbox"/> Abnormal Heart Rhythm/Atrial Fibrillation	<input type="checkbox"/> Other: _____

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

Patient Name: _____ DOB: _____

Other Health Issues

Smoking Status: Never Quit, when? _____ How many years did you smoke? _____
 Current Smoker; how many packs per day? _____ How many years? _____
If current or past, what type? Cigarettes Cigars Pipe Chewing Tobacco

Do you use any recreational drugs? No Yes; which ones? _____

Do you drink alcohol? No Yes; Wine Beer Liquor How many per week? _____

Is violence at home a concern for you? No Yes

Do you require the use of: Cane Walker Wheel Chair

Known Allergies to Food or Medication No Allergies

Medical Contrast Dye Iodine Choloraprep Adhesive/Tape Latex

Allergy and Reaction: _____

Allergy and Reaction: _____

Allergy and Reaction: _____

Allergy and Reaction: _____

Allergy and Reaction: _____

Do you take any of the following:

Coumadin/Warfarin Xarelto Clpidogrel/Plavix Apixaban/Eliquis Aspirin Pradaxa

Who manages lab work? _____ Location: _____

Preferred Pharmacy

Name: _____ Phone: _____

Address: _____

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

Patient Name: _____ DOB: _____

Current Medications

Please list prescription and non-prescription medications, vitamins, cold remedies and herbals.

Medication Name and Purpose	Dosage (Amount)	Frequency (How often)

Family Medical History

Please check if the following health problems affect your family and identify their relationship to you (mother, father, brother, sister, grandparent or child).

<input type="checkbox"/> Alcohol/Drug Abuse _____	<input type="checkbox"/> Emphysema/COPD _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Bleeding Problem _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Blood Clots _____	<input type="checkbox"/> High Cholesterol _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Obesity _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Depression / Anxiety _____	<input type="checkbox"/> Thyroid Problems _____
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Varicose Veins _____
<input type="checkbox"/> Dialysis _____	<input type="checkbox"/> Other: _____

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

Patient Name: _____ DOB: _____

Review of Systems

Please check all that apply:

	Constitution	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Unexpected weight change
	<input type="checkbox"/> Other: _____	
	Respiratory	
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Home oxygen	<input type="checkbox"/> Asthma	
	<input type="checkbox"/> Other: _____	
	Cardiovascular	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Myocardial Infarction
	<input type="checkbox"/> Other: _____	
	Gastrointestinal	
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Other: _____	
	Genitourinary	
<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Frequency
<input type="checkbox"/> Hematuria	<input type="checkbox"/> Scrotal swelling	<input type="checkbox"/> Urgency
<input type="checkbox"/> Urine decreased	<input type="checkbox"/> Other: _____	

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

	Musculoskeletal	
<input type="checkbox"/> Arthralgias	<input type="checkbox"/> Back pain	<input type="checkbox"/> Joint swelling
	<input type="checkbox"/> Other: _____	
	Skin	
<input type="checkbox"/> Color change	<input type="checkbox"/> Rash	<input type="checkbox"/> Wound
	<input type="checkbox"/> Other: _____	
	Neurological	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Light-headedness
	<input type="checkbox"/> Other: _____	
	Hematological	
<input type="checkbox"/> Adenopathy	<input type="checkbox"/> Bruises/bleeds easily	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Other: _____	

GYN (Females Only)

Date of Last Menstrual Cycle: _____	Age of First Menstruation: ____ Age of Menopause: ____
Total Number of Pregnancies: _____	Number of Live Births: _____
Pregnancy Complications: _____	

 Patient Name (Please Print)

 Date

 Patient/Guardian Signature

 Relationship to Patient

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*