ECCO MEDICAL
ENDOVASCULAR CONSULTANTS OF COLORADO

8080 Park Meadows Drive, Suite 150
Lone Tree, CO 80124
720-668-8818 office | 877-229-5440 fax

Patient Name: _____ DOB: _____

Current Medications

Do you currently take any of the following:

☐ Coumadin/Warfarin ☐ Xarelto ☐ Clipidogrel/Plavix ☐ Apixaban/Eliquis ☐ Aspirin ☐ Pradaxa

Please list current prescription medications. You can also bring your own list to your first visit.

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

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.*

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Patient Name: _____ DOB: _____

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

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

Any Prior Anesthesia Complications?

☐ No ☐ Yes; Please explain:_____

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Allergies:
☐ No Known Allergies

Specific Allergies:
☐ Medical Contrast Dye ☐ Iodine ☐ Chlorapprep ☐ Adhesive/Tape ☐ Latex

Other Allergies:
Allergy and Reaction: _____

Allergy and Reaction: _____

Allergy and Reaction: _____

Allergy and Reaction: _____

Allergy and Reaction: _____

Patient Surgical History

Surgery	Year

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Patient Name: _____ DOB: _____

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).

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

Social History

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

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