ENDOVASCULAR CONSULTANTS OF COLORADO

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

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.*

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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

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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 _____

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Patient Name:_____DOB: _____

Have you received a flu shot this year? _____ Have you received a pneumonia shot this year? _____

Have you fallen in the past year? _____ If yes, how many times? _____

What was the reason for the falls? _____

What is your current height? _____ What is your current weight? _____

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:

☐ 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:_____

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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: _____

Preferred Lab for Blood Work

Name: _____Phone: _____

Address: _____

Do you take any of the following:

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

Who manages lab work?_____ Location: _____

Preferred Pharmacy

Name:_____Phone: _____

Address: _____

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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 – specify maternal/paternal 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: _____

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Review of Systems
Please check all that apply:

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

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	Musculoskeletal	
☐ Arthralgias	☐ Back pain	☐ Joint swelling
	☐ Other: _____	
	Skin	
☐ Color change	☐ Rash	☐ Wound
	☐ Other: _____	
	Neurological	
☐ Dizziness	☐ Headaches	☐ Light-headedness
	☐ Other: _____	
	Hematological	
☐ Adenopathy	☐ Bruises/bleeds easily	☐ Anemia
	☐ 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

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