PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

PARAGON HEALTH P.C., DBA ADVANCED VASCULAR SURGERY

KRISHNA M. JAIN, M.D., F.A.C.S.
JOHN S. MUNN, M.D., F.A.C.S.
MARK C. RUMMEL, M.D., F.A.C.S.
DANIEL J. JOHNSTON, M.D.
SYED M.F. ALAM, M.D.

Note: This is a confidential record and will be kept in my office. This information will not be released to anyone without your authorization. (269) 492-6500 or 1-800-448-9684

Name ______________________ Birthdate __________ Sex ______ Age __________
(First) (M.I.) (Last)

Address ______________________ City __________ Zip __________
Home Phone __________ Work Phone __________ Race __________
In an Emergency Contact ______________________ Phone __________
Please list names of physicians you are seeing now ______________________

____

Hospital Preference: Borgess __________ Bronson __________

Reason For Coming To Our Practice

____

____

____

____

Medications: (List those you are taking now or attach a list)

Name of Medication Dose

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

Allergies: Are you allergic to any food or medication? ***Please circle: Yes or No***

Allergy to: Reaction:

1. __________ __________
2. __________ __________
3. __________ __________
4. __________ __________
5. __________ __________

History of Past and Present Medical Conditions

Do you now, or have you in the past, had any of the following? ***Please circle yes or no***

Migraine headaches	yes	no	when ______
Epilepsy or convulsions	yes	no	when ______
Stroke	yes	no	when ______
Glaucoma	yes	no	when ______
Cataracts	yes	no	when ______
Asthma	yes	no	when ______
Chronic bronchitis	yes	no	when ______
Tuberculosis	yes	no	when ______
Pneumonia	yes	no	when ______
Emphysema	yes	no	when ______
Heart attack	yes	no	when ______
Congestive heart failure	yes	no	when ______
Rheumatic fever	yes	no	when ______
Pacemaker	yes	no	when ______
High blood pressure	yes	no	when ______
Stomach or duodenal ulcer	yes	no	when ______
Vomiting blood	yes	no	when ______
Rectal bleeding	yes	no	when ______
Colon or bowel trouble	yes	no	when ______
Kidney problems	yes	no	explain ______
Phlebitis	yes	no	when ______
Blood clots in arteries	yes	no	when ______
DVT/Deep Vein Thrombosis	yes	no	when ______
PE/Pulmonary Embolism	yes	no	when ______
Diabetes	yes	no	how long ______
Gout	yes	no	when ______
High cholesterol	yes	no	when ______
High triglycerides	yes	no	when ______
Thyroid - overactive	yes	no	when ______
- underactive	yes	no	when ______
Nervous breakdown	yes	no	when ______
Arthritis	yes	no	where ______
Cancer	yes	no	where ______
Do you have any blood diseases?	yes	no	what ______

Operations: Were any of the following operated on? (***Please circle yes or no*** and if known, list date and city or hospital)

Tonsils	yes	no	when ______
Appendix	yes	no	when ______
Gall bladder	yes	no	when ______
Stomach	yes	no	when ______
Kidney	yes	no	when ______
Colon	yes	no	when ______
Thyroid	yes	no	when ______
Hernia	yes	no	when ______
Varicose veins	yes	no	when ______
Heart bypass	yes	no	when ______
Heart Angioplasty	yes	no	when ______
Heart Stent	yes	no	when ______
Back	yes	no	when ______

Operations: Were any of the following operated on? (***Please circle yes or no*** and if known, list date and city or hospital)

Arteries	yes	no	which artery/arteries ________
Breast	yes	no	when ________
Uterus	yes	no	when ________
Ovaries	yes	no	when ________
Prostrate	yes	no	when ________
Kidney transplant	yes	no	when ________
Dialysis graft	yes	no	when ________
Dialysis catheter	yes	no	when ________

Other ________

Family History

Has any blood relative ever had any of the following? ***Please circle yes or no***

AAA/abdominal aortic aneurysm	yes	no	who ________
Blood clots/DVT	yes	no	who ________
Cancer	yes	no	who ________
Diabetes	yes	no	who ________
Heart trouble	yes	no	who ________
High blood pressure	yes	no	who ________
Stroke	yes	no	who ________
Bleeding disorder	yes	no	who ________
Varicose veins	yes	no	who ________
Vascular disease	yes	no	who ________

Other ________

Personal and Social History

Please circle response

Marital Status: Married Single Divorced Widowed

Any children?	yes	no	Number of children ____ Your occupation ________
Do you smoke?	yes	no	If yes, what? ________ How much? ________
Do you drink?	yes	no	How much? ________
On a special diet?	yes	no	If yes, what kind? ________

System Review

Circulatory system: Do you or did you experience any of the following? ***Please circle yes or no***

Coldness	yes	no	If yes, where? ________
Change in color	yes	no	If yes, where? ________
Leg cramps - during day	yes	no	How far can you walk before they occur? ________
- during night	yes	no	________
Pain or cramps in foot at night	yes	no	
Varicose veins	yes	no	
Ulcerations	yes	no	If yes, where? ________

Constitutional

Fever	yes	no
Chills	yes	no
Weight loss	yes	no

Allergies;

Seasonal	yes	no
Food	yes	no

If yes, what? ________

Other ________

System Review

Neurological ---

Vision changes:		
Blurring	yes	no
Loss of vision in an eye	yes	no
Double Vision	yes	no
Dizziness	yes	no
Difficulty with balance	yes	no
Weakness (one side of body)	yes	no
Numbness	yes	no
Passing out spells	yes	no
Speech difficulty	yes	no
Memory loss	yes	no

Heart ---

Shortness of breath at night	yes	no
Swollen ankles	yes	no
Chest pains with exercise	yes	no
Unusual heart beat (palpitations)	yes	no

Lungs ---

Coughing up blood	yes	no
Wheezing	yes	no
Shortness of breath		
- on exertion	yes	no
- at rest	yes	no
Frequent cough	yes	no

Gastrointestinal ---

Poor appetite	yes	no
Indigestion or heartburn	yes	no
Abdominal pains	yes	no
Diarrhea	yes	no
Constipation	yes	no
Recent change in bowel habits	yes	no
Black, tar-lie stools	yes	no

Genitourinary ---

Pain or blood when urinating	yes	no
Difficulty passing urine or straining	yes	no
Kidney failure	yes	no
Prostate trouble	yes	no
Difficulty having erections	yes	no
Difficulty maintaining erections	yes	no

Bones and Joints ---

Painful joints	yes	no
Swollen joints	yes	no
Broken bones	yes	no

Breast ---

Breast lump	yes	no
Nipple discharge	yes	no

Hematological ---

Excessive Bleeding/Bruising	yes	no
Abnormal clotting	yes	no

______________________________ ____________________

(Patient's Signature / or Legal Guardian's Signature) (Date)

______________________________ ____________________

(Physician's Signature) (Date)

CONST - 2	SKIN - 1	EYES - 1	ENT - 1	NECK - 1	CARDIO - 8	RESP - 2
GI - 3	NEURO - 2	EXTR - 1	MUSK - 1			