How did you hear about IVY Cardiovascular & Vein Center?
□ Physician Referral
□ Online/Advertisement
□ Family/Friend Referral
□ Other: ____________________________________

PATIENT INFORMATION

Date: ____________________________ Primary Language Spoken: __________________________________

Name: _______________________________________ DOB: __________________________ Age: ________

Gender: □Male □Female Race/Ethnicity: □Asian □Black/African American □Hispanic/Latino □ White

Address: ____ City: ___________________ Zip Code: ________

Phone Number: ___________________________ Email Address: ___________________________________

Primary Care Physician: ______________________________ Phone Number: __________________________

Referring Physician (if different): _________________________ Phone Number: __________________________

Reason for Visit: ____

Pharmacy: __________________________________ Address: _______________________________________

Phone Number: _________________________ Medication Supply Preference: □30 day supply □90 day supply

EMERGENCY CONTACT

Emergency Contact: ________________________________ Phone Number: ___________________________

Relationship: □Spouse □Child □Parent □Other: ____

INSURANCE

Primary Insurance: ____________________________ Policy#: ________________ Group#: _______________

Subscriber: ____ Subscriber DOB: _______________________

Relationship to Subscriber: □Self □Spouse □Child □Other: ____

Secondary Insurance: __________________________ Policy#: ________________ Group#: _______________

Subscriber: ____ Subscriber DOB: _______________________

Relationship to Subscriber: □Self □Spouse □Child □Other: ____

Name: ______________________________ DOB: ____________________

Please check all that apply.

MEDICAL HISTORY

- ☐ Anemia
- ☐ Aortic Aneurysm
- ☐ Arrhythmia/Irregular Heartbeat
  - Atrial fibrillation (A. fib)
  - Atrial flutter
  - Bradycardia
  - Supraventricular tachycardia (SVT)
  - Palpitations
  - Ventricular Arrhythmia
- ☐ Asthma/COPD/Emphysema
- ☐ Blood Clots
  - Deep Vein Thrombosis (DVT)
  - Pulmonary Embolism (PE)
- ☐ Bleeding Disorder
- ☐ CVA/Stroke/TIA
- ☐ Cancer
- ☐ Cardiomyopathy/Heart Failure
- ☐ Carotid Artery Disease
- ☐ Congenital Heart Disease
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Endocarditis
- ☐ GERD
- ☐ GI Bleed
- ☐ Gastrointestinal Ulcer
- ☐ Heart Valve Abnormalities/Heart Murmur
- ☐ Hyperlipidemia/ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Neuropathy
- ☐ Peripheral Vascular Disease
  - Peripheral Artery Disease
  - Venous Disease
  - Varicose Veins
- ☐ Pulmonary Hypertension
- ☐ Renal Artery Stenosis
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Syncope
- ☐ Thyroid Disease
- ☐ Other: ______________________________

SURGICAL HISTORY

☐ Cardiac Catheterization	Date: __________	Physician: ____________________
☐ Cardioversion	Date: __________	Physician: ____________________
☐ Coronary Angioplasty/Stent	Date: __________	Physician: ____________________
☐ Coronary Artery Bypass (CABG)	Date: __________	Physician: ____________________
☐ ICD Placement	Date: __________	Physician: ____________________
☐ Pacemaker Placement	Date: __________	Physician: ____________________
☐ Peripheral Vascular Angioplasty/Stent	Date: __________	Physician: ____________________
☐ Peripheral Artery Bypass/Endarterectomy	Date: __________	Physician: ____________________
☐ Radiofrequency Ablation	Date: __________	Physician: ____________________
☐ Heart Valve Repair/Replacement	Date: __________	Physician: ____________________
☐ Aneurysm Repair	Date: __________	Physician: ____________________
☐ Carotid Surgery	Date: __________	Physician: ____________________
☐ Amputation	Date: __________	Physician: ____________________
☐ Other: ____________________	Date: __________	Physician: ____________________

Name: ______________________________ DOB: ____________________

SOCIAL HISTORY

Marital Status: □Single □Married □Divorced □Widowed

Occupation: ____________________

Do you consume alcohol? □Yes □No □Former
Frequency: ____________

Do you smoke/use tobacco? □Yes □No □Former
Number of years: ____________
Packs per day: ____________

Do you use illicit drugs? □Yes □No □Former
Substance type: ____________

Do you exercise regularly? □Yes □No
If YES, describe: ____________________

FAMILY HISTORY

Is there any family history of:

□ Myocardial Infarction/Heart Attack	□Yes	□No	Family Member(s): ____________
□ Stroke/CVA	□Yes	□No	Family Member(s): ____________
□ Coronary Artery Disease	□Yes	□No	Family Member(s): ____________
□ Diabetes	□Yes	□No	Family Member(s): ____________
□ Hypertension (High Blood Pressure)	□Yes	□No	Family Member(s): ____________
□ Sudden Death	□Yes	□No	Family Member(s): ____________
□ Hyperlipidemia/High Cholesterol	□Yes	□No	Family Member(s): ____________

REVIEW OF SYSTEMS

Recent weight gain or loss	□Yes	□No
Chest pain, pressure or tightness	□Yes	□No
Shortness of breath at rest	□Yes	□No
Shortness of breath with activity	□Yes	□No
Short of breath lying flat	□Yes	□No
Cough	□Yes	□No
Heart palpitations/heart racing	□Yes	□No
Dizziness/vertigo/fainting	□Yes	□No
Fever/Chills	□Yes	□No
Swelling of ankles/feet	□Yes	□No
Non-healing sores on legs/feet	□Yes	□No
Leg pain/cramps with walking	□Yes	□No
Leg pain at rest	□Yes	□No
Fatigue/malaise	□Yes	□No
Weakness	□Yes	□No
Headaches	□Yes	□No
Changes in vision	□Yes	□No
Memory loss	□Yes	□No

Name: ______________________________ DOB: ____________________

ALLERGIES

Do you have any allergies to medications, foods, latex, seafood/IV dyes? □Yes □No

If YES, please list:

______________________________ Reaction: ______________________________

______________________________ Reaction: ______________________________

______________________________ Reaction: ______________________________

______________________________ Reaction: ______________________________

MEDICATIONS

Medication Name	Dose	Frequency