



Diversified Vein
and Interventional Clinic

Patient Name: _____
Age: _____ DOB: _____
Today's Date: _____
Evaluating Physician: _____
Referring MD: _____ Phone: _____

Interventional Radiology Patient Questionnaire

How did you hear about Diversified Vein and Interventional Clinic? _____

What are your goals or expectations of this treatment? _____

Reason for today's visit? _____

When did your symptoms or problem occur? _____

What treatments/test have you had for your current symptoms or problem? _____

Past Medical History: (Check all current or previous medical conditions that apply)

- Asthma Depression High Cholesterol Mental Illness
- Bleeding Problems Diabetes HIV Seizures
- Blood Clots Heart Disease Kidney Disease Stroke
- Cancer Hepatitis Liver Disease Ulcer
- COPD High Blood Pressure Lung Disease
- Other conditions _____

Past Surgical History: (Please list any previous surgical procedures, and the date of surgery)

- Tonsillectomy Arthroscopy
- Spine Gallbladder
- Appendectomy Hernia Repair
- Other _____

Medications: (Please list all medications you are currently taking including over the counter)

	NAME OF MEDICATION	DOSE	HOW OFTEN TAKEN
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Allergies:

1. List medicine allergies and reactions:

2. Have you ever had "x-ray dye" or Intravenous contrast? _____ If so, explain _____

3. Do you tolerate Advil or Motrin? _____ Can you take relaxation medication (Valium/Morphine)? _____

4. Any trouble with Sedation/Anesthesia in the past with you or any of your family members? Please list _____

Family History:

Family Member	Alive	Deceased	Age	Current/Past Medical Conditions
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Social History:

Occupation _____

Currently Working? Yes No

Highest level of education completed: Grammar High School College Post Graduate

Are you on? Social Security Disability Workers compensation

Marital Status: Single Married Widowed Separated Divorced

Tobacco use: Yes, I've used _____ packs/per day for _____ years.
 No, I quit _____ years ago, I used _____ packs/per day for _____ years.
 No, I have never used tobacco.

Alcohol use: Yes, Daily _____ 1 or more times per week 1 or more times per month
 No, I quit _____ years ago, I used to drink _____ drinks per week.
 No, I don't drink alcoholic beverages

Recreational Drugs: Yes List _____ or No

Review of Systems: (Please circle any problems or symptom you have had or currently have)

General: Recent illness, fever, chills, night sweats, weight loss/gain.

Skin: Bruising/bleeding disorders, rashes, itching, skin cancer, other disease of the skin _____.

Cardiovascular: Shortness of breath, palpitations, chest pain, swelling in extremities, murmur, angina.

Respiratory: Chronic cough, wheezing, pain with breathing, productive cough.

Gastrointestinal: Nausea, vomiting, diarrhea, constipation, heartburn, ulcers, blood in stool, jaundice.

Genitourinary: Blood in urine, difficulty controlling bowel/bladder, urinary frequency/urgency or burning.

Neurological: Headaches, seizures, tremors, paralysis, loss of consciousness, dizziness.

Musculoskeletal: Joint pain, tingling, burning, backache, neck ache, fatigue.

Psychological: Anxiety, suicidal thoughts, mood swings, constant crying, loss of sleep.

Pt Name: _____ Date _____

Pt Signature: _____ Date _____

*****This page to be filled out by physicians office*****

Patient Name: _____ **Date:** _____

Physical Exam:

V/S: Temp _____ Resp _____ Pulse _____ B/P (R/L) _____ SAO2% _____ Ht _____ Wt _____ lb

Imaging: _____

Physician Notes: _____

Assessment and Plan: _____

Patient Instructions: _____

Pharmacy Used/ Location: _____