McLaren

BAY HEART & VASCULAR

HISTORY AND PHYSICAL

Insurance Information:
Medicare _____ Medicaid _____
Other _____

Date of Visit: _____
New ❑ F/U ❑

Patient Name: _____
DOB: _____ Age: _____

Surgeon: _____
Primary care provider: _____
Referring provider: _____
Reason for visit: _____
_____

History of Present Illness

Vascular Risk Factors

❑ Tobacco abuse (current, former) ____ packs ____
❑ Diabetes: Insulin Oral Diet
❑ Hypertension ❑ Hypercholesterolemia
❑ CAD ❑ CHF ❑ MI
❑ Hypercoagulable state
❑ Obesity ❑ Sedentary

Past Medical History

❑ See vascular risk factors

Past Surgical History

Previous Interventions

Vascular Percutaneous Intervention Date(s)

Vascular Surgery Date(s): Procedure(s):

Non-Invasive Testing (Date/Results)

Medications

❑ See medication requisition sheet
❑ New medications ❑ No changes

Allergies (note reactions)

❑ None known ❑ Medications ❑ Latex ❑ IV Contrast

Social History

❑ Employed: _____
Retired: _____
Disabled: Reason _____
❑ Marital status: Married Single Divorced
Number of children ____
Are you being abused or neglected? ____
ETOH: Recreational drugs:

Family History

Mother: _____ ❑ Deceased
Father: _____ ❑ Deceased
Siblings: _____ ❑ Deceased
Children: _____ ❑ Deceased

Signature: _____ Date: _____ Time: _____

PT.

MR.#/RM.

DR.

McLaren

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Patient Name:

Review of Systems

❑ No change

Constitutional:	**Yes**	**No**	**Gastrointestinal:**	**Yes**	**No**	**Neurological cont.:**	**Yes**	**No**
Fatique			Nausea/Vomiting			Numbness/Tingling		
Fevers/Chills			Indigestion/Reflux			Muscle weakness/Paralysis		
Weight change			Swallowing difficulties			**Psychological:**		
EENT:			Pancreas/Gall Bladder dz.			Depression		
Glasses/Glaucoma/Cataracts			Liver disease/Jaundice			Psychosis		
Tongue/Mouth/Throat problems			Diarrhea/Constipation			Anxiety		
Nasal allergies/Nose problems			Rectal bleeding			Mood disorders		
Dentures/Teeth problems			Abdominal pain			**Genitourinary:**		
Ear/Hearing disorders			Hermia			Pain with urination		
			Musculoskeletal:			Incontinence of urine		
Cardiovascular:			Spine disease/Surgery			Urinary frequency		
Chest pain/MI/CHF			Neck/Back pain			Difficulty emptying bladder		
Palpitations/Arrhythmias			Arthritis/Joint disease			Sexual dysfunction		
Pain in calves while walking			Muscle injuries/Disease			Unusual vaginal bleeding		
DVT/PE/Varicosities/Venous ulcers			**Neurological:**			**Skin:**		
Respiratory:			Headache			Unusual rash, moles or spots		
Cought			Amaurosis/Diplopia			Ulcerations		
Shortness of breath			Stroke/TIA			**Endocrine:**		
Wheezing/Asthma			Seizure disorder			Thyroid disease		
Smoking			Gait disturbance			Diabetes		
			Dizziness					

Physical Exam

Height: Weight: BMI: Right BP: Left BP:

Heart Rate: Temp: Sa02: Nutritional Counsel Offered ❑ Yes ❑ No

General:

Skin: Ulcers:

HEENT: ❑ WNL ❑ Other:

Pulmonary: ❑ WNL ❑ Other:

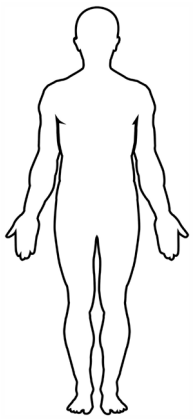
Cardiac: ❑ WNL ❑ Other:

Neurologic: ❑ WNL ❑ Other:

Abdominal: ❑ WNL ❑ Abdominal bruit

Extremity: ❑ WNL ❑ Other:

Able to perform ADL's?



Assessment and Plan:

❑ Patient Understanding

MD/NP/PA Signature: _____ Date: _____ Time: _____ Dictation #: _____

Schedule:

Test: _____

Procedure: _____

Follow up appointment: _____ week(s) _____ month(s) _____