

First Name: _____

Last Name: _____

Referring Physician: _____

Pharmacy Name: _____

Primary Med. Doctor: _____

Pharmacy Phone #: _____

Cardiologist: _____

SOCIAL SECURITY # (SURGICAL SCHEDULING PURPOSES ONLY_ VALLEY HOSPITAL): _____

Do you have any Allergies to Medications? Yes/ No

If yes, Please list: _____

Do you take any of the following medications:

Aspirin 81 mg Aspirin 325 mg Plavix (Clopidogrel) Brilinta Effient

Statin/cholesterol medication: _____

Blood thinner: Eliquis/ Xarelto/ Pradaxa/ Coumadin/ Warfarin

SOCIAL HISTORY: (Check all that Apply)

1. Do you currently smoke? Yes/ No

If Yes, How many years have you smoked for? _____

If Yes, At what age did you start smoking? _____

If Yes, How many packs per day do you smoke? ½ pack 1 pack

2. Are you a Former smoker? Yes/ No

If Yes, At what age did you start smoking? _____

How many years did you smoke for? _____

3. Do you use any other forms of tobacco or nicotine? Yes/ No

4. What is your level of alcohol consumption? None/ Occasional/ Moderate/ Heavy

5. Do you use any illicit or recreational drugs? Yes/ No

6. What is your level of caffeine consumption? None/ Occasional/ Moderate/ Heavy

Family History: Do any family members have any of the following conditions:

Father Aortic Aneurysm Bleeding Disorder DVT Heart Disease

Mother Aortic Aneurysm Bleeding Disorder DVT Heart Disease

Siblings Aortic Aneurysm Bleeding Disorder DVT Heart Disease

List Previous Operations and Year

1. _____

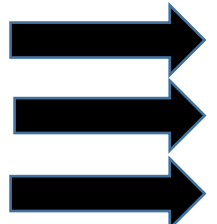
2. _____

3. _____

4. _____

5. _____

6. _____



TURN OVER(FILL OUT BACK OF PAGE)

Do you have any of the following: (Check all that Apply)

- Anemia
 - Anticoagulation therapy
 - Arthritis
 - Asthma
 - Atrial fibrillation
 - Bleeding disorder
 - COPD/emphysema/asthma
 - Cancer _____
 - Clotting disorder
 - Congestive heart failure
 - Coronary artery disease
 - Deep venous thrombosis
 - Other: _____

- Diabetes
 - Heart disease
 - High cholesterol/hyperlipidemia
 - Hypertension/High Blood Pressure
 - Kidney disease
 - Neurological disorder
 - Pacemaker
 - Pulmonary embolism
 - Sleep disorder/Sleep Apnea
 - Stroke
 - Use oxygen at home
 - Varicose veins

Height _____

Weight _____

Reason for Current Visit:

Describe the Symptoms:

When /How/ Where it Started:

How frequent are the symptoms/severity of symptoms:

Anything make your symptoms better or worse? :