Patient Name: _____ **Date:** _____

Are you on dialysis? Yes No If yes, what days? _____

Dialysis center name and address: _____

Dialysis phone #: _____

Do you smoke or vape? Never Former Current, list frequency: _____

Allergies (Please do not leave this section blank)

☐ No known allergies

List all medication(s) you are allergic to and reaction (Aspirin, Penicillin, etc.):

_____

List any other allergies you have (contrast dye, tape, latex, iodine, etc.): _____

Medication List

Blood thinners you are currently taking: _____

Please list **ALL** **Prescription** **Medication** you are currently taking or provide us with a list to copy.

Name of Medicine (Ex: Lisinopril)	**Dosage** (Ex: 25mg)	**Administration** (Oral, injection, topical)	**Frequency** (How many times a day)

Patient Name: _____ Date: _____

*Please check ALL that applies to you

Past Medical History

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV

HENT

- ☐ Sudden vision loss

Cardiovascular

- ☐ Congestive heart failure
- ☐ **Heart attack**
- ☐ **High blood pressure**
- ☐ **Heart disease**
- ☐ **Irregular heart beat**

Respiratory

- ☐ Asthma
- ☐ Oxygen use
- ☐ Sleep apnea/CPAP
- ☐ COPD/Emphysema

Endocrine

- ☐ **Diabetes**
- ☐ **High cholesterol**
- ☐ Thyroid problems

Neurologic/Psychiatric

- ☐ Alzheimer's / Dementia
- ☐ Seizure disorder
- ☐ **Stroke/TIA**
- ☐ Neuropathy

Genitourinary

- ☐ Kidney failure

Skin

- ☐ Open wounds

Vascular

- ☐ Aneurysm
- ☐ Blocked arteries in legs
- ☐ Varicose/Spider veins
- ☐ Blood clot in leg (DVT)
- ☐ Carotid blockage
- ☐ Blood clot in lungs (PE)
- ☐ Leg swelling

Family Medical History - Please check all that apply to your family history.

- ☐ Aneurysm
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke

Past Surgical History – Please list any **Abdominal**, **Groin**, **Heart**, **Neck**, and **Vascular** surgeries **ONLY**.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____