VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC OF JACKSON

VIRC
Vascular and Interventional Radiology Clinic of Jackson

HISTORY AND PHYSICAL

TODAY'S DATE: ______________________

PATIENT

NAME-LAST	FIRST	M.I.	DATE OF BIRTH	AGE	SEX ❑ M ❑ F	SOCIAL SECURITY NO.
HOME ADDRESS	CITY		STATE	ZIP CODE	MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED	
TELEPHONE NUMBER HOME	WORK				CELL / OTHER	
IN CASE OF EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE				RELATIONSHIP	
PRIMARY CARE PHYSICIAN					DATE OF LAST VISIT	
EMPLOYER/OCCUPATION						

INSURANCE

WHO SHOULD WE THANK FOR YOUR REFFERAL	REFERRING PHONE NUMBER (IF APPLICABLE)
INSURANCE COMPANY	EMPLOYER OF INSURED
POLICY HOLDER	ID NUMBER
GROUP AND OR POLICY NUMBER	PRE-CERTIFICATION PHONE NUMBER

PRESENT ILLNESS INFORMATION

CURRENT PROBLEMS	CURRENT SEVERITY OF PROBLEM	PREVIOUS TREATMENTS FOR PROBLEM
1) 2) 3)	PLEASE RATE YOUR CONDITION ON A SCALE OF 1-10 WITH 1 BEING NORMAL LIFESTYLE AND 10 BEING SEVERE EFFECTS ON LIFESTYLE 1 2 3 4 5 6 7 8 9 10	
4)	WHEN DID YOU FIRST NOTICE THE PROBLEM?	HOW OFTEN DO YOU HAVE THESE PROBLEMS?
5)	FAMILY HISTORY OF SIMILAR PROBLEMS ❑ YES ❑ NO	

WHAT IS THE MEDICAL PROBLEM YOU NEED ADDRESSED TODAY?

DOES ANYTHING MAKE YOUR PROBLEM WORSE OR BETTER?

HAVE YOU BEEN EVALUATED FOR THIS PROBLEM BEFORE (WHAT WAS THE DIAGNOSIS GIVEN?)

IT IS VERY HELPFUL FOR THE PATIENT AND/OR FAMILY TO COMPLETE THIS SO WE CAN BETTER CARE FOR YOU. PLEASE CIRCLE ALL TRUE ANSWERS.

THE MAIN REASON I AM HERE TODAY IS: ____ WHEN STARTED__________________________

MY DOCTOR IS ____

I HAVE A HISTORY OF: NONE
- HEART DISEASE
- CONGESTIVE HEART FAILURE
- STROKES ANEURYSM
- CANCER
- HIGH BLOOD PRESSURE
- ASTHMA EMPHYSEMA
- DIABETES
- HIGH CHOLESTEROL
- PRIOR HEART ATTACK
- OTHER_______________

MY SURGERIES INCLUDE: NONE
- HYSTERECTOMY TUBAL
- GALL BLADDER
- HEART BYPASS HEART STENT
- HEART ANGIOPLASTY OR BALLOON
- HIP / KNEE / BACK
- TONSILS
- APPENDIX
- PRIOR ANGIO OR STENTS TO LEGS.
- OTHER_______________

MY FAMILY HAS A HISTORY OF:
- HIGH BLOOD PRESSURE
- HEART DISEASE
- DIABETES
- HIGH CHOLESTEROL
- STROKES
- ANEURYSM
- CANCER
- NONE

I DO OR DO NOT USE ALCOHOL
HOW MUCH_________DAY

I DO OR DO NOT USE TOBACCO/SMOKE
HOW MANY______PACKS/DAY
HOW LONG_______YEARS
I QUIT. WHEN?_________

LAST MENSTRAL PERIOD DATE_______
NORMAL OR ABNORMAL
BLEEDING OR DISCHARGE NOW
NUMBER OF PREGNANCIES_______
LIVING CHILDREN _____________
MISCARRIAGES ______________
PREGNANT NOW _____________
DUE DATE ___________________

DAILY LIVING: ___NO PROBLEM
____EATING NEEDS ASSISTANCE
RECENT DECLINE
____DRESSING NEEDS ASSISTANCE
RECENT DECLINE
____BATHING NEEDS ASSISTANCE
UNABLE
RECENT DECLINE

I LIVE WITH: FAMILY ALONE NURSING HOME OTHER

THE FOLLOWING PROBLEMS APPLY TO ME TODAY: CIRCLE

GENERAL	HEART	LUNG	ABDOMEN	KIDNEY	HEAD
FEVER/CHILLS	CHEST PAIN	COUGH	NAUSEA	PAINFUL URINATION	HEADACHE
WEIGHT LOSS	HEART MURMUR	WHEEZING	VOMITING	BLOOD IN URINE	SEIZURE
DIZZY	IRREGULAR HEART BEAT	SHORT OF BREATH	PAIN	DIFFICULT URINATION	PASSING OUT
FALLS/INJURY	SWELLING LEGS	BLOOD CLOTS	DIARRHEA	KIDNEY DISEASE	CONFUSION
NONE	**NONE**	**NONE**	**NONE**	**NONE**	**NONE**

EYES/EARS	NOSE, MOUTH, THROAT	MUSCLES	BLOOD	GLANDS	PERSONAL
EYE PAIN	BLEEDING NOSE/GUMS	TENDERNESS	ANEMIA	THYROID DISEASE	ANXIETY
VISION CHANGE	CONGESTION	WEAKNESS	EASY BRUISING	DIABETES	DEPRESSION
HARD OF HEARING	SORE THROAT	ARTHRITIS	**NONE**	**NONE**	ABUSE AT HOME
NONE	**NONE**	**NONE**			**NONE**

COMPLETED BY ____ DATE ______________________________

DOCTOR REVIEWED____ DATE ______________________________

ALLERGIES:

OFFICE USE ONLY:

MEDICATIONS:

PHYSICAL EXAM

PHYSICAL EXAMINATION

PROBLEM FOCUSED 1-5, EXPANDED PROBLEM FOCUSED 6, DETAILED 12, COMPREHENSIVE ALL SHADED PLUS 1 UNSHADED					
HEIGHT *	WEIGHT *	BP *	TEMP *	PULSE *	RESP *

CONSTITUTIONAL *	NORMAL	WD	WN			
HEENT *	NORMAL	EOMI	JVD	SUPPLE	BRUIT	
RESPIRATORY *	NORMAL	CTA	TRACH MIDLINE	RESP EFF		
CARDIOVASCULAR *	NORMAL	MURMUR	RUB	BRUIT	EDEMA	PULSES
ABDOMEN *	NORMAL	BS	MASSES	TENDERNESS		
PELVIC / RECTAL	NORMAL	DEFFERED				
SKIN	NORMAL	CLUBBBING	CYANOSIS	RASH	LESION	VARICOSITIES
MS	NORMAL	GAIT	UNSTEAD	WEAKNESS		
NEUROLOGICAL	NORMAL	STRENGTH	GRIP	CN II-XII		
PSYCHIATRIC	NORMAL	ORIENTATION	MS	MOOD	AFFECT	

PLAN ______________________________

FU ______________________________

FU ______________________________

PHYSICAL SIGNATURE ______________________________ DATE