Vascular Institute of Michigan

1325 S. Linden Road Flint, MI 48532
Phone: (810) 535-5555
Fax: (810) 275-1556

PLEASE COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT.
Note: This is a confidential record and will be kept in our office. This information will not be released to anyone without your authorization

Patient Name: ______ (First) ______ (M.I) ______ (Last)   D.O.B ______ (mm) (dd) (yyyy)

Sex ______ Age ______ Race ______

Address ______ State ______ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Emergency Contact Name ______ Relationship ______ Phone ______

Please list names of any physicians you are currently seeing: ______

______

______

Physicains Verified :

Referral: ______

Primary: ______

Nephrologist: ______

Podiatrist: ______

Cardiologist: ______

Reason for coming to our practice: ______

______

______

Medications: list those you are now taking or attach a list)

	Name of medication	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Patient Name ______________________ D.O.B ______________

Constitutional

Please select all that apply

- Fever ☐
- Chills ☐
- Weightloss ☐

Heent

Please select all that apply

- Dizziness ☐
- Ringing in the ears ☐
- double vision ☐
- Nearsghited ☐
- Farsighted ☐
- Loss of vision ☐
- Eye pain ☐
- Floaters in field of vision ☐
- Blindness ☐
- Cataracts ☐
- Lumps/fibrocystic ☐
- Loss of hearing ☐
- Frequent colds ☐
- Dental problems ☐
- Hoarseness ☐
- Bleeding gums ☐
- Difficulty swallowing ☐
- Painful swallowing ☐
- Frequent ear infections ☐
- Toothache ☐
- Sore throat ☐
- Snoring ☐
- Dentures ☐
- Neck stiffness ☐
- Loss of smell ☐
- Post nasal drainage ☐
- Sore gums/mouth ☐

Phychiatric

Please select all that apply

- Depression ☐
- Anxiety ☐
- Bipolar disorder ☐
- OCD ☐

Allergies

Please select all that apply

- Seasonal ☐
- Food ☐

If yes, what? ______________________

____

Other ______________________

Gastrointestinal

Please select all that apply

- Constipation ☐
- Hemorrhoids ☐
- Vomiting ☐
- Diarrhea ☐
- Coffee ground emesis ☐
- Stomach cancer ☐
- Decreased appetite ☐
- Colon cancer ☐
- Stomach/duodenal ulcer ☐
- Hiatal henia ☐
- Heartburn/GERD ☐
- Blood in stool ☐
- Gallstones ☐
- Tar-like/black stools ☐
- Nausea ☐
- Recent change in weight ☐
- Inflammatory bowel disease ☐
- Chrohn's diease ☐
- IBS ☐

Cardiovascular

Please select all that apply

- Angina ☐
- Chest pain ☐
- Congestive heart failure ☐
- Atrial fibrillation ☐
- Palpitations ☐

Skin

Please select all that apply

- Rash ☐
- Hair loss ☐
- Acne ☐
- Change in hair/nails ☐
- Psoriasis ☐
- Dryness ☐
- Ulcer (s) ☐

General

Please select all that apply

- Fatigue ☐
- Night sweats ☐
- Generalized weakness ☐
- Marked weight gain ☐
- marked weight loss ☐
- Change in appetite ☐
- Fever ☐
- Headache ☐
- Malaise ☐

Neurological

Please select all that apply

- Paralysis ☐
- Dementia ☐
- Alzheimer's disease ☐
- Dizziness/vertigo ☐
- Parkinson's disease ☐
- Syncope ☐
- Insomnia ☐
- Multiple sclerosis ☐
- Poor balance ☐
- numbness ☐
- CVA(stroke) ☐
- TIA(mini stroke) ☐
- Seizures ☐
- Restless leg syndrome ☐
- Migranes/severe headaches ☐
- Peripheral neuropathy ☐
- Ruptured disc ☐
- Brain injury ☐
- Neuropathy ☐

Endocrine

Please select all that apply

- Sensitive to cold or heat ☐
- Diabetes ☐
- Thyroid problems ☐
- Goiter ☐
- Taking thyroid medication ☐
- Dryness ☐
- Ulcer (s) ☐

Patient Name D.O.B

Respiratory

Please select all that apply

- Persistent cough ☐
- Shortness of breath ☐
- Emphysema ☐
- Pulmonary embolus ☐
- Productive cough ☐
- Asthma ☐
- Lung cancer ☐
- Speel apnea ☐
- CPAP/BiPAP use ☐
- O2 dependent ☐
- Tuberculosis ☐
- Wheezing ☐
- COPD ☐
- Orthopnea ☐
- Dyspnea ☐
- Tobacco use ☐
- Lobectomy ☐
- Pneumothorax ☐
- Pneumonia ☐

Peripheral vascular

Please select all that apply

- Poor circulation ☐
- Peripheral arterial disease ☐
- Diabetes ☐
- Unhealing wounds ☐
- Amputation ☐
- Pain with walking ☐
- Bulging varicose veins ☐
- Swelling ☐
- Redness ☐
- Pale appearance ☐
- Coolness in extremities ☐
- Numbness/tingling in extremities ☐
- Pain in extremities ☐
- Raynaud's Syndrome ☐
- Lymph node enlargement ☐

Hematology/oncology

Please select all that apply

- Anemia ☐
- Bleeding disorder ☐
- Blood clots (DVT) ☐
- Pulmonary embolus ☐
- Superficial blood clot ☐
- Thrombophlebitis ☐
- Easy bruising ☐
- Heapatitis ☐
- HIV ☐
- HTT (Heparin induced thrombocytopenia) ☐

Genitourinary

Please select all that apply

- Painful urination ☐
- Urinary Incontinence ☐
- Pelvic inflammitory disease ☐
- Hematuria ☐
- Difficult urination ☐
- Cloudy urine ☐
- Sediment in the urine ☐
- Frequent urination ☐
- Bladder infections ☐
- Kidney disease ☐
- Dialysis ☐
- Frequent UTI's ☐
- Congestive heart failure ☐
- Atrial fibrillation ☐
- Palpitations ☐
- Dependent edema ☐
- Heart attack ☐
- Slow heart rate ☐
- Fast heart rate ☐
- Shortness of breath ☐
- Rheumatic fever ☐
- Pacemaker ☐
- ASD/VSD/PFO ☐
- Murmur ☐
- Blood clots ☐
- MVP ☐
- Syncope ☐
- Near syncope ☐
- Dizziness ☐
- Fatigue ☐
- Fluid in legs ☐
- Fluid in ankles ☐
- Arm discomfort ☐
- Jaw pain ☐
- Shoulder pain ☐
- Defibrillator ☐
- Coronary artery disease ☐
- Stents ☐
- CABG ☐

Musculoskelatal

Please select all that apply

- Muscle cramps ☐
- Back pain ☐
- Joint swelling/stiffness ☐
- Difficulty walking ☐
- Weakness ☐
- Neck pain ☐
- Arthritis ☐
- Leg cramps ☐
- Generalized aches ☐
- Joint pain ☐
- Osteoarthritis ☐
- Rheumatoid arthritis ☐
- Lupus ☐

Patient's / or Legal Gaurdian's signature Date

CONST-2	SKIN-1	EYES-1	NECK-1	CARDIO-8
RESP-2	GI-3	NEURO-1	EXTR-1	MUSC-1

VASCULAR INSTITUTE OF MICHIGAN

Directions to VIM

North

When traveling to VIM from the North: Please head south on Linden Rd. Turn left at W. Court St. Enter the first entrance on the left. VIM will be the first building on the right.

South

When traveling to VIM from the south: Please head north on Linden Rd. Turn right at W. Court St. Enter the first entrance on the left. VIM will be the first building on the right.

East

When traveling to VIM from the east (I-75): Please head west on Corunna Rd. towards Linden Rd. Turn right on Linden Rd. Turn right at the first set of lights (W. Court St.) Turn left at the first entrance on your left. VIM will be the first building on your right.

West

When traveling to VIM from the west: Please head east on Corunna Rd. towards Linden Rd. Turn left on Linden Rd. Turn right at the first set of lights (W. Court St.) Turn left at the first entrance on your left. VIM will be the first building on your right.

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Mohmmed Margni, MD - Babatunde Almaroof, MD

Patient Name ______________________ D.O.B ______________

Allergies: are you allergic to any food or medication? Please circle: Yes or No

Allergy to: Reaction:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

History of past and present medical conditions

Do you now, or have you in the past, had any of the following? Please select "yes" or "no".

Condition	Yes	No	
Migrane Headaches	☐ Yes	☐ No	When ______
Epilepsy or convulsions	☐ Yes	☐ No	When ______
Stroke	☐ Yes	☐ No	When ______
Glaucoma	☐ Yes	☐ No	When ______
Cataracts	☐ Yes	☐ No	When ______
Asthma	☐ Yes	☐ No	When ______
Chronic Bronchitis	☐ Yes	☐ No	When ______
Tuberculosis	☐ Yes	☐ No	When ______
Pneumonia	☐ Yes	☐ No	When ______
Emphysema	☐ Yes	☐ No	When ______
Heart attack	☐ Yes	☐ No	When ______
Congestive heart failure	☐ Yes	☐ No	When ______
Rheumatic fever	☐ Yes	☐ No	When ______
Pacemaker	☐ Yes	☐ No	When ______
High blood pressure	☐ Yes	☐ No	When ______
Stomach or duodenal ucer	☐ Yes	☐ No	When ______
Vomiting blood	☐ Yes	☐ No	When ______
rectal bleeding	☐ Yes	☐ No	When ______
Colon or bowel trouble	☐ Yes	☐ No	When ______
kidney problems	☐ Yes	☐ No	Explain ______
Phlebitis	☐ Yes	☐ No	When ______
Blood clots in arteries	☐ Yes	☐ No	When ______
DVT/Deep Vein Thrombosis	☐ Yes	☐ No	When ______
PE/Pulmonary Embolism	☐ Yes	☐ No	When ______
Diabetes	☐ Yes	☐ No	How long ______
Gout	☐ Yes	☐ No	When ______
High cholesterol	☐ Yes	☐ No	When ______
High triglycerides	☐ Yes	☐ No	When ______
Thyroid-overactive	☐ Yes	☐ No	When ______
Thyroid-underactive	☐ Yes	☐ No	When ______
Nervous Breakdown	☐ Yes	☐ No	When ______
Cancer.	☐ Yes	☐ No	When ______
Do you have any blood diseases	☐ Yes	☐ No	What ______

Patient Name ______________________ D.O.B ______________

Operations: were any of the following operated on? Select "yes" or "no". If known, list date and city or hospital

Tonsils	☐ Yes	☐ No	When ______
Apendix	☐ Yes	☐ No	When ______
Gall Bladder	☐ Yes	☐ No	When ______
Stomach	☐ Yes	☐ No	When ______
Kidney	☐ Yes	☐ No	When ______
Colon	☐ Yes	☐ No	When ______
Thyroid	☐ Yes	☐ No	When ______
Hernia	☐ Yes	☐ No	When ______
Varicose veins	☐ Yes	☐ No	When ______
Heart bypass	☐ Yes	☐ No	When ______
Heart angioplasty	☐ Yes	☐ No	When ______
Heart stent	☐ Yes	☐ No	When ______
Back	☐ Yes	☐ No	When ______
Arteries	☐ Yes	☐ No	When ______
Breast	☐ Yes	☐ No	When ______
Uterus	☐ Yes	☐ No	When ______
Ovaries	☐ Yes	☐ No	When ______
Prostate	☐ Yes	☐ No	When ______
Kidney transplant	☐ Yes	☐ No	When ______
Dialysis graft	☐ Yes	☐ No	When ______
Dialysis catheter	☐ Yes	☐ No	When ______

Other ______________________

Family History: Has any blood relatice ever had any of the following? pleases select "yes" or "no"

AAA/Abdominal Aortic Aneurysm	☐ Yes	☐ No	When ______
Blood clots/DVT	☐ Yes	☐ No	When ______
Cancer	☐ Yes	☐ No	When ______
Diabetes	☐ Yes	☐ No	When ______
Heart trouble	☐ Yes	☐ No	When ______
High blood pressure	☐ Yes	☐ No	When ______
Stroke	☐ Yes	☐ No	When ______
Bleding disorder	☐ Yes	☐ No	When ______
Varicose veins	☐ Yes	☐ No	When ______
Vascular disease	☐ Yes	☐ No	When ______

Other ______________________

Personal and Social History

Marital status: ☐ Married ☐ Single ☐ Divorcedv ☐ Widowed

Any children? ☐ Yes ☐ No Number of children ______ Your occupation ______

Do you smoke? ☐ Yes ☐ No If yes, what? ______ How much? ______

Do your drink? ☐ Yes ☐ No How much? ______

On a special diet? ☐ Yes ☐ No If yes, what kind? ______

System Review

Circulatory Suystem: Do you or did you experience any of the following? Please select all that apply

Coldness ☐ If yes, Where? ______

Change in skin color ☐ If yes, Where? ______

Daytime leg cramps ☐ How far can you walk before the cramps occur? ______

Nightime leg cramps ☐ ______

Nightime foot cramps ☐

Varicose veins ☐ If yes, Where? ______

Skin ulcerations ☐ If yes, Where? ______