Summit Cardiology Vascular Lab Patient Intake Form

Date: ______________

Patient name: _______________________ DOB: ________ Height: _______ Weight:_____

Doctor ordering the study: ______________________

Primary care physician: _________________________

Reason for the study, if known: ____

Are you experiencing symptoms? (Check those that apply)

□ visual loss
□ weakness or loss of sensation
□ slurred speech, difficulty forming sentences
□ difficulty finding words
□ temporary memory loss
□ dizziness/fainting
□ leg or hip pain with walking
□ non-healing sores on feet
□ swelling/edema
□ abdominal pain with eating

Have you had any of the following? (Check those that apply)

□ high blood pressure □ coronary artery disease □ a heart attack
□ a stroke or "mini-stroke"
□ carotid artery disease
□ peripheral artery disease (PAD)
□ vein problems
□ blood clots
□ aortic aneurysm or enlarged aorta
□ family history of aneurysm

Have you had previous vascular surgery? (Check those that apply)

□ carotid artery surgery
□ bypass operation in legs or abdomen
□ arterial stents/angioplasty
□ aneurysm surgery
□ vein stripping, ligation, ablation, laser treatment

Do you have or are you being treated for: (Check all those that apply)

□ hypertension □ high cholesterol □ diabetes
Do you have a family history of coronary artery disease? Yes □ No □
Do you or have you ever smoked cigarettes? Yes □ No □

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