VERO VASCULAR SURGERY, P.A.

W. Clark Beckett, M.D., F.A.C.S.

Board Certified Vascular Surgeon

3770 7th Terrace, Suite 101 * Vero Beach, Florida 32960 * 772.567.6602 * Fax 772.567.7754

PATIENT HISTORY FORM

Date:_____

Name_____ D.O.B._____

(Last) (First) (Middle)

Briefly describe your symptoms:

_____

_____

Please list the names of other physicians:

_____

_____

_____

_____

_____

Height: _____

Weight: _____

Stocking size: _____ (nurse will record)

Thigh: _____ Calf_____

Ankle: _____ Length: _____

BP: (Nurse will record) Left: _____ Right: _____ Pulse: _____

Please note current dialysis graft or fistula location: _____

Drug Allergies: Yes____ No_____ If Yes, Please list:

Name of Drug:	**Reaction:**
_____	_____
_____	_____
_____	_____
_____	_____

Other allergies:

_____

_____

Personal History:

Marital Status:

Never Married ___ Divorced___ Married ___ Separated ___ Widowed ___ Partner/ Significant other___

Currently working: Yes ____ No____ Retired_____ Disabled_____

Occupation: _____

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Social History

1. Tobacco Use: **Yes: ____No: ____Never: ____How much: _____**

Age Started: _____Age Quit: _____Years Smoked: _____ Year Quit: _____

Type: Cigarette: _____ Pipe: _____ Cigars: _____ Chew: _____ Marijuana: _____

2. Alcohol Use: **Yes: _____No: _____ How Much: _____ How often: _____**

Year Quit: _____

Type: Beer: _____ Wine: _____ Liquor: _____

3. Exercise: **Yes: _____ No: _____ Describe: _____**

4. Nursing Mother: **Yes: _____ No: _____**

Family History:

Please list age and any medical conditions. **If Deceased: Please note cause of death**

Father:_____ _____

Mother: _____ _____

Siblings: _____ _____

Children: _____ _____

Does anyone in your family have history of varicose veins? Yes_____ No_____

Please list name/relation: _____

GENERAL INFORMATION:

2. Current Medications: ****Please include dosage and instructions for taking your medications****

****** You may provide your own list if you have one******

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. Surgeries: (Include Dates) ****** You may provide your own list if you have one******

_____

_____

_____

_____

_____

_____

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MEDICAL HISTORY: (Please check all that apply)

GENERAL:	Never	Past	Current
Headaches			
Dizziness			
Blurred/Double Vision			
Cataracts			
Recent weight gain/loss			

NEUROLOGICAL:	Yes	No
Seizure History		
Paralysis		
Tremors		
TIA's (mini stroke)		
Stroke		
Parkinson's		
Alzheimer's		
Weakness		
Loss of consciousness		
Numbness		
Balance problems		
Peripheral Neuropathy (Numbness/ tingling in legs)		

CARDIOVASCULAR:	Never	Past	Current
Chest Pain/pressure			
High Blood Pressure			
High Cholesterol			
Congestive Heart Failure			
Heart Attack			
Irregular Heart Beat			
Murmur			
Palpitations(Racing heartbeat)			
Leg swelling			
Chronic (Present long time)			
New onset			

VASCULAR:	Never	Past	Current
Varicose Veins			
Spider Veins			
Deep Vein Clot			
Superficial Vein Clot			
Pulmonary Embolus (clot in lungs)			
Calf/ thigh cramps with walking			
Wounds/ulcers			
? slow healing			

RESPIRATORY:	Yes	No
Shortness of breath		
At rest		
With exertion		
Chronic Cough		
COPD		
Asthma		
Wheezing		
Coughing up blood		
Chronic or past lung Disorder		
Pneumonia		

DIGESTIVE:	Never	Past	Current
Heart Burn			
Nausea/Vomiting			
Constipation			
Ulcer Disease			
Abdominal Pain			
Vomiting Blood			
Bloody/Black stool			
Liver Disease			

KIDNEY/ BLADDER: GENITOURINARY	Never	Past	Current
Frequent Urination			
Incontinence			
Difficulty Urination			
Kidney Disease			
Kidney Stones			
Blood in urine			

MUSCLES/ BONES/ JOINTS:	Yes	No
Back Pain		
Muscle Weakness		
Arthritis		
Osteoporosis		
Joint pain/swelling		

HEMATOLOGY/ ONCOLOGY/ ENDOCRINE:	Never	Past	Current
Anemia			
Easy bruising			
Clotting disorder			
Cancer			
-Leukemia			
Diabetes			
Thyroid Disorder			

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MEDICAL HISTORY (CONTINUED)

IMMUNE SYSTEM/ INFECTIOUS DISEASE:

	Yes	No	Ever
Hepatitis	____	____	_____
MRSA infection	____	____	_____
Jaundice	____	____	_____
HIV/Aids	____	____	_____
Tuberculosis	____	____	_____

PSYCHIATRIC:

	Yes	No	Ever
Depression	____	____	_____
Anxiety	____	____	_____
Poor Appetite	____	____	_____
Hallucination	____	____	_____

Do you have any other Health care concerns not mentioned previously:

_____

_____

_____

_____

_____

_____

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Patient Name: _____ **DOB:**_____

SECTION A: PATIENT INFORMATION **Date:**

NAME: LAST_____FIRST_____INITIAL_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE_____CELL PHONE_____MARITAL STATUS: _____

PATIENT SS#_____ DATE OF BIRTH_____AGE: _____

PERSON RESPONSIBLE FOR BILL (if patient is a minor) _____

EMPLOYER_____OCCUPATION_____

STREET ADDRESS_____CITY_____ST_____ZIP_____

PHONE #_____ REFERRED BY_____

SECTION B: SPOUSE INFORMATION

NAME_____DATE OF BIRTH_____SOC.SEC.#_____

STREET ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE_____CELL PHONE_____

SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME_____RELATIONSHIP_____PHONE_____

How did you hear about us? (Circle one) Friend Physician Other_____

SECTION D: PREFERRED PHARMACY

Name: _____Location: _____

SECTION E: **PLEASE BRING YOUR PHOTO ID & INSURANCE CARDS**

PRIMARY INSURANCE

INS.CO.NAME_____

ID#_____GROUP#_____

SECONDARY INSURANCE

INS.CO.NAME_____

ID#_____GROUP#_____

We request the following information to better treat medical conditions which may be related to these items and to ensure communication is clear. Please take a moment to answer each of these.

Race: _____ Preferred Language: _____

Ethnicity: (Circle one) Hispanic or Non-Hispanic or Other_____

By signing below, I authorize Vero Vascular Surgery, PA to bill and receive payment from the insurance(s) provided for services rendered. I understand that I am ultimately responsible for these charges and may be billed for amounts not paid by my insurance company. I also understand that it is my responsibility to provide updated insurance information should my coverage change. Failure to pay for any medical services can result in those charges being forwarded to a collection agency.

Patient/Guardian's Signature_____Date_____

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AUTHORIZATION TO RELEASE MEDICAL/FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of **Vero Vascular Surgery, PA (VVS)** to give copies of and/or discuss your condition, exams, procedures, x-rays and financial information with members of your family or other individuals that you designate other that your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

□ **I DO NOT authorize VVS to release any information concerning my care to any individual.**

□ **I authorize VVS to release any/all information including verbal information, copies of x-rays, medical paperwork and financial information concerning my medical care to the following individuals.**

Name: _____Relationship: _____Phone#: _____
Name: _____Relationship: _____Phone#: _____

AUTHORIZATION TO LEAVE PHONE MESSAGE

□ **I authorize VVS to leave detailed messages at □Home phone □Cell phone**

□ **I DO NOT authorize VVS leave a detailed message on my answering machine or voicemail. I acknowledge in choosing this option that I, the patient/Guardian, assume full responsibility for contacting VVS regarding any/all testing results.**

MEDICATION ACCESS AUTHORIZATION

□ **I authorize VVS to obtain/download medication information from my pharmacy.**

□ **I DO NOT authorize VVS to obtain/download medication information from my pharmacy. I acknowledge by choosing this option, I may be limiting my quality of care.**

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how VVS may use and disclose my protected health information. I understand that VVS reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Print Patient Name: _____DOB: _____/_____/_____

Signature of Patient/Guardian: _____Date: _____/_____/_____

PATIENT PORTAL

Our office provides patients with access to their medical record electronically through our Patient Portal. You are also able to email us directly, request appointments, and cancel appointments. If you would like to be signed up for our portal please provide us with your email address and preferred username.

Email:_____ @ _____ . _____

Username: _____(8 characters minimum)

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LIVING WILL/ ADVANCED HEALTH CARE DIRECTIVE

□ I currently have a Living Will or Advanced Directive
□ I DO NOT have a Living Will or Advanced Directive

If you currently have a living will, please provide us with the following information as well as a copy of the document for our records.

Health Care Surrogate:
Name: _____ Relation: _____
Home Phone: _____ Cell Phone: _____
Address: _____

CONSENT TO TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed name of Patient or Representative Relationship to patient