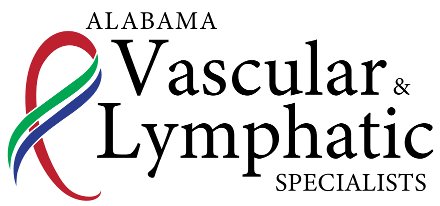


General Information Sheet

Name:______________________________ Date of Birth:______________

Gender: Male Female Social Security #:______________________

Race: African American Asian American Indian/Alaska Native
Native Hawaiian/Pacific Islander Caucasian/White Other

Current Address: ____

____

Height:______________________ Weight:________________ lbs.

Phone Numbers (please check the primary contact number)

Home:______________ Cell:______________ Other:______________

Email Address:____

Emergency Contact:________________________ Phone #:______________

Emergency Contact Relationship:______________________________________

Referring Physician:________________________ Phone #:______________

Primary Care Physician(s):________________________ Phone #:______________

Cardiologist:________________________ Phone #:______________

Other Physician(s):____
Name City, State Phone # Specialty

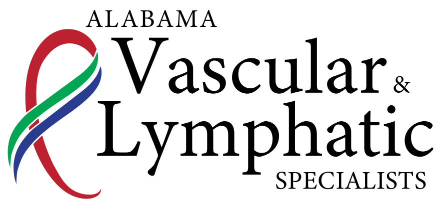
Other Physician(s):____
Name City, State Phone # Specialty

Other Physician(s):____
Name City, State Phone # Specialty

Responsible Party Information (If different than patient information)

Relationship to Patient:________________________ Date of Birth:______________

Name of Responsible Party:________________________ Social Security #:______________



Current Medications

I have included a separate list of all my medications.

Please list any medications you are currently taking:

Medication Name	Dose	Frequency

**If you need additional space to list your medications, please see the bottom of page 6.*

Pharmacy Name: ______________________ Phone #:______________

Pharmacy Address: ______________________________________

Allergies

Please list any known allergies you have and your reaction to them:

No known allergies.

Type of Allergy	Reaction

Are you allergic to seafood? Yes No

Are you allergic to betadine? Yes No

Are you allergic to contrast dye? Yes No

Are you allergic to iodine? Yes No

1. How did you hear about us?

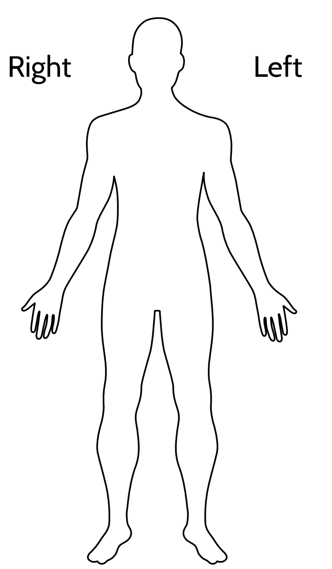
Referred by my doctor
Health fair screen
Internet
Newspaper
TV
In office brochure or TV
From a friend
Magazine
Advertisement in the mail

2. Why are you here?

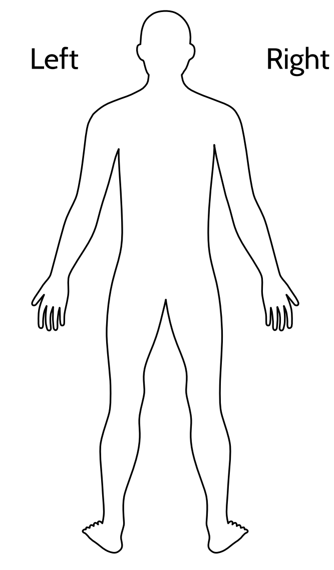
I don't know - my doctor sent me
Abnormal test results
Difficulty walking
Varicose veins
Skin color changes
Leg pain
Leg swelling
Leg sores
Restless legs
Lymphedema
Lipedema
My legs are unusually large compared to the rest of my body.

3. Where does this bother you?

Right Left



Left Right



4. If there is pain, please circle all that apply to describe this pain:

Achy Throbbing Sharp Crampy Numb
Tired Itchy Stinging Burning
Restless Electrical No Pain Heavy

5. How severe is the pain?

1 2 3 4 5 6 7 8 9 10

😃 😐 😡

6. When did this start?

Don't know Day to weeks ago Months ago Years ago

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Bessemer, AL 35022

7. When does it bother you? (Choose all that apply.)

All the time   Every day   Few times a day   Few times a week   Few times a month

8. What makes it worse? (Choose all that apply.)

Standing   Touch/Pressure   Climbing stairs   Sitting   Lying down   Resting
Leg down position   Leg elevation   Walking < 1 block   Walking > 1 block

9. What makes it better? (Choose all that apply.)

Rest   Walking   Standing   Pain medication   Leg elevation   Compression
Exercise   Nothing helps   Leg down/hanging position

10. Are any of these associated with the following? (Choose all that apply.)

Cold feet   Swelling   Tenderness   Numbness   Tingling
Restlessness   Varicose veins   Skin changes   Sores/ulcers   Slow healing
Poor sleep   Skin infections   Poor mood   Anxiety   Depression
Easy bruising   Excessive fatty tissue in the legs that is resistant to weight loss

11. Does any of this interfere with any of the following? (Choose all that apply.)

Walking   Working   Exercise   Shopping   Chores   Sleeping
All of the above

12. Do your calves or thighs hurt when you walk?   Yes   No

If yes, how far can you walk until this hurts?   Less than 2 blocks   More than 2 blocks

If yes, does this pain go away when you rest?   Yes   No

13. Has your ability to walk decreased since last year?   Yes   No

14. Do your legs hurt worse when walking up hill, upstairs, or walk at increased speed?   Yes   No

15. Do your legs hurt when lying down?   Yes   No

If so, does it improve when you stand up or hang your legs off the bed or couch?   Yes   No

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Social History

Name:____ Date of Birth:________________

16. Marital Status:

Married Never Married Divorced Widowed

17. Do you live:

Alone With Spouse With Children With Relatives With Friend/Roommates

18. What is the highest level of education you have completed?

Some High School High School Diploma/GED Some College Associates Degree
Bachelor's Degree Graduate/Professional Degree Technical Degree

19. Do you work?

Full-time Part-time Self-employed
Unemployed. Last date worked: ________________________________

20. What is your occupation?

Unemployed Student Laborer Managerial Professional
Other: ____

21. Do you drink alcohol?

No Previous use Sometimes/Socially
Yes, how much? ____________________________________

22. Do you smoke?

Never smoked Previous smoker Sometimes/Socially
Current smoker, how much? ________________________________

23. Have you used recreational drugs? Yes No

If yes: Previous user Current user

24. Have you used IV drugs? Yes No

If yes: Previous user Current user

25. Are you pregnant? Yes No

26. Are you breastfeeding? Yes No

Family History

Name:____ Date of Birth:______________

27. Does your family have a history of significant medical problems?

	Relationship to you
Diabetes	
Hypertension	
Heart Disease	
Stroke	
Cancer	
Lymphedema	
Vascular Disease	
Blood Clots	

Surgical History

28. Have you previously had any type of surgery? Yes No

If yes, did you have **VASCULAR** or **HEART** surgery? Yes No

Please list any other **TYPE** of surgery and the **YEAR** it was performed:

____

____

____

____

Please list any other important information or continue listing medication here:

____

____

____

____

____

____

____

Contrast Dye Questionnaire

Name: ______________________________ DOB: ___/___/___ Age:_____ Sex: ▢ F ▢ M
Last First

Asthma/Allergy History: Do you have a history of asthma? If not, skip to question 5. ▢ Yes ▢ No

1. Have you had an asthma attack in the last 24 hours? ▢ Yes ▢ No
2. Do you use an asthma inhaler every day or an oral asthma medication every day? ▢ Yes ▢ No
3. Have you ever been hospitalized for asthma? ▢ Yes ▢ No
4. Have you ever had a severe allergic reaction requiring hospitalization, or epinephrine? ▢ Yes ▢ No

Contrast Allergy or Contrast Reaction History

5. Have you ever had an allergic or any other type of reaction to x-ray contrast (x-ray dye?) ▢ Yes ▢ No
6. If yes, what reaction did you have? ▢ Yes ▢ No

Steroid Premedication History

7. Have you ever taken or been instructed to take a steroid medication in preparation for any x-ray with contrast (x-ray dye?) ▢ Yes ▢ No
8. If yes, have you taken a steroid medication in preparation for today's exam? ▢ Yes ▢ No

Kidney Function History

9. Do you have a history of renal disease including: Circle all that apply. ▢ Yes ▢ No

   Dialysis, transplant (single kidney), renal cancer or renal surgery?

10. Do you have high blood pressure requiring medication? ▢ Yes ▢ No
11. Do you have diabetes? ▢ Yes ▢ No
12. Do you take Metformin containing drugs? ▢ Yes ▢ No
    (These are drugs for diabetes, if you are unsure discuss with technologist)

Cardiac History

13. Do you have angina or congestive heart failure? ▢ Yes ▢ No
14. Do you have severe aortic stenosis? ▢ Yes ▢ No
15. Do you have primary pulmonary hypertension? ▢ Yes ▢ No
16. Do you have severe cardiomyopathy? ▢ Yes ▢ No

Myasthenia Gravis: History or prior diagnosis? ______________________ ▢ Yes ▢ No
Multiple Myeloma: History or prior diagnosis? ______________________ ▢ Yes ▢ No
Nursing

Are you nursing a child? ▢ Yes ▢ No

It is generally regarded as safe to continue breastfeeding after receiving contrast. It is your choice however and, if you are still concerned, you may stop for 24 hours following the contrast injection.

Intra-Arterial Contrast: Most patients experience no unusual effects from this injection other than some warmth or minimal flushing which is very common. As with the injection of any medicine or drug however, a few risks are involved, most of which are mild and momentary: slight nausea, or medicinal or metallic taste in the mouth. There can also be minor reaction such as itching, sneezing or a few hives. Uncommonly there can be more serious reactions including kidney failure, thrombophlebitis, skin necrosis and in extremely rare cases, death. Our facilities are equipped to immediately treat these unusual reactions. In ordering this procedure, your doctor has determined that the diagnostic information which is provided outweighs the risk (usually minimal) of the procedure.

I understand the explanation give to me and give my consent to the angiography.

Signature of Patient or Legal Guardian:______________________ Witness:______________________

Patient Name (Print):______________________ Date:______________________

Past Medical History

Name:______________________________ Date of Birth:______________

Which of the following conditions has your Doctor diagnosed you with?

Neurological:

Multiple Sclerosis
TIA
Stroke
Brain Injury
Spinal Cord Injury
Migraines
Seizures
Dysautonomia
Neuropathy

Hepatic:

Liver Failure
Gall Stones
Jaundice

Endocrine:

Cushing's disease
Diabetes
Hypoglycemia
Goiter
Grave's Disease
Liver Disease
Thyroid Disease

Urinary & Reproductive:

Endometriosis
Enlarged Prostate
Incontinence
Fibroids
Interstitial Cystitis
STDs:________________

Vascular:

Arteriosclerosis
Peripheral Vascular Disease
High Blood Pressure
Aneurysm
Hypertension
Varicose Veins

Musculoskeletal:

Rotator Cuff Injury
Joint Replacements

Heart:

Coronary Artery Disease (CAD)
Atrial Septal Defect
Heart Attack
Heart Murmur
Arrhythmia
PFO Closure
Irregular Heart Beat
Mitral Valve Prolapse
Congestive Heart Failure
Atrial Fibrillation
Pacemaker

Rheumatology:

Arthritis (type unknown)
Osteoarthritis
Rheumatoid Arthritis
Gout
Lupus or "SLE"
Ankylosing Spondylitis
Childhood Arthritis
Osteoporosis
Polymyalgia Rheumatic (PMR)
Hypermobility/EDS
Other:________________

Respiratory:

Pleurisy
Respiratory Distress Syndrome
Emphysema
COPD
Asthma
Bronchitis
Pulmonary Hypertension
Tuberculosis

Renal:

Nephritis
Kidney Failure
Kidney Stones

Gastrointestinal:

Ulcers:________________
Crohn's Disease
Colitis
Diverticulosis
Diverticulitis
Irritable Bowel Syndrome
Esophageal Varices
GERD
Pancreatitis
Peptic Ulcers
Barrett's Esophagus

Heme/Oncology:

Cancer:
____
____

Clotting Disorders:
____
____

Bleeding Disorders:
____
____

Myositis
Addison's Disease

Infectious Disease:

Chicken Pox
Mumps
Hepatitis B
Hepatitis C
Parasites
Measles
Malaria
Typhoid Fever
Infectious Mononucleosis (mono)
Traveler's Diarrhea
HIV
Tuberculosis or positive TB test
Other:________________

*Other:*______________________________

None to Report

What Medical Signs or Symptoms Do You Currently Have?

Name:______________________________ Date of Birth:______________

Please check all that apply

Constitutional Symptoms:
- No Symptoms
- Chills
- Fever
- Loss of Appetite
- Poor Sleep/Insomnia
- Night Sweats
- Recent Weight Loss
- Recent Weight Gain
- Generalized Swelling

Eyes:
- Normal
- Eye Pain (circle one)
- Left, Right or Both?
- Vision Loss

Ears, Nose & Throat:
- Normal
- *Ears:*
- Decreased Hearing
- Earache: R or L
- *Nose & Sinuses:*
- Nasal Congestion
- Sinus Trouble
- *Mouth & Throat:*
- Difficulty Swallowing
- Hoarseness

Cardiovascular:
- Normal
- Chest Discomfort
- Chest Pain
- Fainting
- High Blood Pressure
- Leg Cramps at Rest
- Leg Cramps on Exertion
- Leg Swelling

Pulmonary:
- Normal
- Cough
- Asthma
- Pain with Breathing
- Shortness of Breath

Genitourinary:
- Normal
- Frequency
- Incontinence
- Urgency

Gastrointestinal:
- Normal
- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Hepatitis
- Peptic Ulcers
- Indigestion
- Nausea
- Vomiting

Musculoskeletal:
- Normal
- *Neck:*
- Pain
- Stiffness
- *Back:*
- Pain
- Stiffness
- Tenderness
- *Joints:*
- Aching
- Arthritis
- Limitation of Joint Movement
- Redness
- Morning Stiffness
- Swelling
- Tenderness
- *Muscles:*
- Aches
- Weakness

Skin, Hair, Nails:
- Normal
- *Hair:*
- Falling Out
- Itching & Scaling of the Skin
- Hair Loss on Legs
- *Nails:*
- Discoloration
- Excessively Dry or Brittle Nails
- *Skin:*
- Change in Skin Pigmentation/Color
- Easy Bruising
- Rash
- Sores/Wounds

Neurological:
- Normal
- Blackouts
- Change in Behavior
- Headaches
- Involuntary Movements
- Numbness
- Paralysis
- Seizures
- Speech
- Tingling
- Tremors
- Unsteadiness/Dizziness
- Weakness

Psychiatric:
- Normal
- *Mood:*
- Anxiety
- Depression
- Mood Swings
- Nervousness
- Stressed
- *Mental State:*
- Hallucinations
- Paranoid
- Memory Loss
- Suicidal Ideation

Endocrine:
- Normal
- Cold Intolerance
- Excessive Sweating
- Excessive Thirst
- Heat Intolerance
- Hot flashes

Hematologic/Lymphatic:
- Normal
- *Hematologic:*
- Bruises Easily
- Bleeding
- History of Anemia
- History of Transfusion Reactions
- History of Blood Clots
- *Lymphatic:*
- Enlarged Lymph Nodes

Immunologic:
- Normal
- HIV
- Persistent Infections

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