Sharon Hammond M.D. **Mandi Phillips NP**
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NEW PATIENT EVALUATION

Patient name: _____

DOB: _____ Insurance: _____

PCP: _____Referring Provider: _____

COMPLAINT / HISTORY OF PRESENT ILLNESS (circle the symptoms you are experiencing)

Burning itching heaviness/fatigue numbness throbbing dry skin impaired mobility

painful /bleeding varicosities edema/swellingcramps restless legs active ulcers skin changes/discoloration

Aches/pain- please specify in pain scale from 0-10 (0 is no pain - 10 is the greatest pain you experienced) Where you would rate your pain _____

Symptoms are located: _____ Symptoms began: _____

CHECK ALL THAT APPLY: **** *You must mark **NO** or **N/A** if it doesn't apply*****

_____ Symptoms are worse on the left
_____ Symptoms are worse on the right
_____ Symptoms are slightly better after leg elevation and/or walking
_____ Symptoms are worse after prolonged sitting or standing
_____ Difficulty sitting for more than _____minutes
_____ Difficulty standing for more than _____ minutes
_____ Difficulty walking for more than _____minutes

Compression stockings __ yes __no When did you start _____ How many hours a day_____
How did it help? _____

Elevate legs __ yes __ no When did you start _____ How much time a day_____

NSAIDS (ex. Advil) __yes __ no When did you start _____ Strength/# _____ How often do you take them_____

Weight reduction ___ yes __ no # lbs. lost _____ How long has your weight been reduced _____

Exercise/walking yes __ no When did you start _____ Do you exercise daily___ For how long_____

Avoidance of prolonged standing yes __ no When did you start _____

Other life style modifications: _____

Patient Name: _____

D.O.B: _____

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How does your symptoms interfere with these activities of daily living. For instance, do you need to take breaks, if so, how long and how often do you take a break? Have you had changes in wearing shoes, clothing, sleeping habits, or any other, if so, for how long? **** *You must mark **NO** or **N/A** if it doesn't apply* ****

Cooking/cleaning _____

Dressing/grooming _____

House chores_____

Sleeping _____

Performing my job _____

Others-please specify: _____

Previous vein treatment- please specify_____

MEDICATIONS: **** You must mark **NO** or **N/A** if it doesn't apply****

List all medicines, steroids, inhalers, supplements (prescription or over-the-counter) you are currently taking:

Medication	Dosage	Frequency	Route (Oral, Inj.,Patch etc.)

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MEDICAL HISTORY (check all that apply)

___ No medical problems

___ Coronary artery disease (CAD)

___ Peripheral Arterial Disease (PAD)

___ History of Stroke

___Peripheral neuropathy

___ Hypertension

___ Hyperlipidemia

___Hyperthyroidism

___History of Cancer

___ Atrial Fibrillation/Arrhythmia(irregular heart beat)

___Diabetes

___Hepatitis A B C

___ Benign prostate hypertrophy

___Asthma

___Osteoporosis

___COPD

___DVT

___Hypercoagulable states

___ Lupus

___Spinal problem (back problem low back pain)

OTHER: _____

_____

ALLERGIES (list allergies and reactions or circle none) NONE

ALLERGIC TO: REACTION:

_____ _____

_____ _____

_____ _____

Are you allergic to Latex? Yes No

Have you had problems with general anesthesia? No I don't know Yes- explain: _____

_____

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ADVANCED CARE PLAN

Do you have an Advanced Care Plan? Yes No

If YES, please provide the name and contact information for you surrogate decision maker (below):

_____

_____

SURGICAL HISTORY (please list any surgeries and the date)

_____ _____

_____ _____

_____ _____

HOSPITALIZATIONS (other than surgery)

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY Please indicate if any family member has had any of the following:

Medical condition	Family Member (s)
Diabetes	
Blood Pressure/Hypertension problems	
Elevated cholesterol	
Cancer (type:	
Heart problems/Chest pain	
Stroke/TIA	
Bleeding problems	
Blood clots	
Varicose veins	
Reaction to anesthesia	
Other:	

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SOCIAL HISTORY

Alcohol use: no alcohol drinks ____ per week drink occasionally

Tobacco use: never smoked former smoker currently smoke _____ daily

Recreational drug use: _____

Special diet - please specify:_____

Exercise program-please specify: _____

Occupation: _____ working full time working part time retired

Marital status: _____

Children: No Yes - How many: _____

REVIEW OF SYSTEMS (circle all that apply)

General: fever /chills weight change change in appetite night sweats

Dermatology: acne rash concerning lesions eczema hives mole nail changes

HEENT: visual changes drainage in ear runny nose sneezing sore throat trouble swallowing

Respiratory: cough chest pain with breathing shortness of breath on exertion sputum wheezing

Cardiology: chest pain with exertion murmurs palpitations irregular heart rhythm

Gastroenterology: bloating blood in stool change in bowel habits cirrhosis reflux abdominal pain

Genitourinary: blood in urine pain on urination incontinence penile/vaginal discharge

Musculoskeletal: joint pain joint redness joint swelling injury: _____

Neurology: confusion memory loss dizziness seizures

Psychology: anxiety depression excessive worry problem focusing irritability poor concentration

Hem/Lymph: anemia bleeding easy bruising enlarged lymph nodes chills

Endocrinology: hair loss hot flashes intolerance to cold/heat excessive drinking of water
weight change sexual dysfunction

Last influenza immunization: _____ Last pneumonia immunization: _____