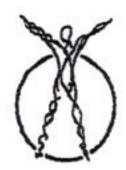


## Skylands Vascular Specialists

Bobby Rupani, M.D., R.V.T. Alaina Guiliana, A.P.N.

Date o	Date of Birth:		
First Name:	Middle initial:		
City:	State:	Zip:	
Cell phone:			
Sex:	Social Securit	y#	
Occupation:	Work phone:		
Ethnic origin:	Race:		
ion:			
Relationship:	Phone:		
home/cell phone with test re	sults? Home:   YES   N	O Cell: - YES - NC	
nember about your care and te	st results?   YES   NO		
an:	Phone:		
	Phone:		
on:			
	Phone:		
	First Name:  City:  Cell phone:  Sex:  Occupation:  Ethnic origin:  Relationship:  home/cell phone with test research	First Name: Middle Initial: City: State: Cell phone: Sex: Social Securit Occupation: Work phone: Ethnic origin: Race: Ion: Relationship: Phone: home/cell phone with test results? Home: PYES = Nonember about your care and test results? Phone: Phone: Phone:	



## Skylands Vascular Specialists

Bobby Rupani, M.D., R.V.T. Alaina Guiliana, A.P.N.

Primary Insurance:		
Policy Holder Name:	Date of Birth:	
Policy Number:		
Secondary Insurance:		
Policy Holder Name:	Date of Birth:	
Policy Number:		
Designation of Certain Relatives, Cloud agree that the practice may disclose certain of personal friend or other caregiver, since such person's involvement with my health care or person's involvement with my health care or person's involvement below as persons involved the purpose of the practice making the am not required to list anyone. I also understated	of my health information berson is involved with all disclose only informa- bayment relating to my wed with my health care be limited disclosures de	n to a family member, close my health care or payment relating tion that is directly relevant to the health care. I designate the e or payment relating to my health scribed above. I understand that I
Name	Relationship	Phone Number
Assignment of Benefits/Authorization I hereby authorize payment directly to physicial hereby authorize the release of pertinent med	ans providing services for	or which benefits are payable. I
Signature:		Date:
Financial Responsibility Agreement I understand that I am financially responsible for balance of possible insurance benefits payment referred to collection.	or all charges for servic	
Signature:		Date:

## **Medications:**

If you have a list already, please provide a copy to the front desk.

	ation	Dosage	Frequency		Do	oconin-
		Doodec	riequeitcy		Kei	asoning
					+	
					+-	
					+-	
					_	
		-				
llergies:	Check here if none					
	Check here ii none					
acial lufa			The second of th			
ocial Inforn	nation:					
obacco:	What is your cu	What is your current smoking status?				FORMER
					SMOK	
	if current smoke	er, how many	y per day?			
	If former smoke	r. when did	VOLL QUÍ+2			,
lcohol:					/	/
iconoi:	Do you drink wi	ne, beer, or l	iquor?	□YES	□NO	
		,,				
			week?			
rugs:	If yes, how man	y drinks per				
rugs:		y drinks per v				

General	Leg pain at rest	Painful joints
	Leg pain with exertion	Deformities of the joints or
Weakness	Blue/purple discoloration of	extremities
Lack of appetite	hands/feet	
Weight Loss		Neurologic
	Gastrointestinal	Weakness, headaches, pre-
Eyes		syncope, syncope
Decreased ability to see	Nausea	Blackouts
Loss of vision	Vomiting	Dizziness
LOSS OF VISION	Diarrhea	Double vision
	Abdominal pain	Numbness or tingling of the
Skin	Abdominal pain after eating	extremities
Skin	Blood in stools	Paralysis or weakness of
Change in skin color or		limbs
temperature		Loss of sensation
Hair growth change, ulcers	Genito-urinary System	
Nail changes	Dain an hamain an an antanatan	Loss of balance or
Skin ulcers	Pain or burning on urination	coordination
Skiii dicers	Frequent urination	Problems speaking
	Unusually large volumes of	
Respiratory	urine	n
nespiratory	Extreme urge to urinate	Psychiatric
Asthma		Depression
Shortness of breath at rest	Endocrine	Anxiety
Shortness of breath with	Endocrine	
exertion	Heat intolerance	
	Cold intolerance	<b>Contact Precaution</b>
	increased thirst	
Cardiovascular		HIV
		Hepatitis C
Chest pain/tightness/	Musculoskeletal	MRSA
squeezing, irregular heartbeat		C-DIFF
Need to sit up to breathe	Neck Pain (Bone, joint or	Norovirus
Irregular heart beat	muscle problems)	TB
(palpitations)	Back pain	Measles
Swelling of the legs Varicose Veins	Right arm pain	Chicken pox
	Left arm pain	Staphylococcus Aureus
Heaviness	Pain down your legs	
Achiness	Right leg pain	
Fatigue	Left leg pain	

PAST MEDICAL HI	STORY	: PLEA	SE CHECK WHETHER YOU	MAVI	EVER	HAD THE FULLOWING:		
	NO	YES		NO	YES		NO	YES
Anemia			Diabetes Mellitus			Nerve/muscle disease		
Anxiety			Emphysema			Osteoporosis		
Arthritis			GERD			Seizures		
Asthma			Glaucoma			Sickle Cell Anemia		
Atrial Fibrillation			Heart murmur			Stroke		
Cancer			Hepatitis			Thyroid Disease		
Cataracts			Hyperlipidemia			Tuberculosis		
CHF			Hypertension			Uicers (GI)		
Clotting Disorder			Kidney Disease			Vitamin D deficiency		
COPD			Meningitis					
Dementia			Myocardial Infarction					
Depression								
PLEASE LIST ANY	THER	MEDIA	CAL CONDITIONS.					
PLEASE LIST AIRT (	JINEK	MEDI	LAL CONDITIONS:					
							•	_
PAST SURGICAL H	STORY	: PLEA	SE CHECK WHETHER YO	U HAV	E HAD	THE FOLLOWING:		
	NO	YES		NO	YES		NO	YES
Appendectomy			C-Section			Small intestine surgery		
<b>Brain Surgery</b>			Eye surgery			Spine surgery		
Breast Surgery			Fracture Surgery			Tonsillectomy		
CABG			Hernia repair			Tubal ligation		
Cholecystecomy	0		Hysterectomy			Valve replacement		
Colon Surgery			Joint Replacement			Vasectomy		
			Prostate Surgery					
DI FACE LICT AND	THE .					Other: please list		
PLEASE LIST ANY O								
<b>FAMILY HISTORY:</b>	DIFAS	E LIST	ANY SIGNIFICANT FAMIL	Y ME	DICAL I	HISTORY (i.e. Diabetes, Hy	perte	nsion,
Stroke, Clotting Di								
Stroke, Clotting Di								
Stroke, Clotting Di Mother:								
Stroke, Clotting Di Mother: ather:								