Skylands Vascular Specialists

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

Patient information:		Date of Birth:
Last Name:	First Name:	Middle Initial:
Address:	City:	State: Zip:
Home Phone:	Cell phone:	
Email:	Sex:	Social Security #
Employer:	Occupation:	Work phone:
Primary Language:	Ethnic origin:	Race:

Emergency Information:		
Name:	Relationship:	Phone:
Can we leave a message on home/cell phone with test results? Home: ☐ YES ☐ NO Cell: ☐ YES ☐ NO		
Can we speak to a family member about your care and test results? ☐ YES ☐ NO		
If yes, please list name (s): _____		

Primary Care Physician:	Phone:
Referring Doctor:	Phone:

Pharmacy Information:	
Primary Pharmacy:	Phone:
Mail-In Pharmacy (if applicable):	

Reasoning for today's visit:

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Primary Insurance:	
Policy Holder Name:	**Date of Birth:**
Policy Number:	
Secondary Insurance:	
Policy Holder Name:	**Date of Birth:**
Policy Number:	

Designation of Certain Relatives, Close Friends, and Other Caregivers:

I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I designate the following person listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list any time in writing.

Name	Relationship	Phone Number

Assignment of Benefits/Authorization to Release Information

I hereby authorize payment directly to physicians providing services for which benefits are payable. I hereby authorize the release of pertinent medical information to insurance carriers.

Signature:_____ **Date:**_____

Financial Responsibility Agreement

I understand that I am financially responsible for all charges for services to me, including the remaining balance of possible insurance benefits payments. I will also pay all recovery costs if my account is referred to collection.

Signature:_____ **Date:**_____

Medications:

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

Name of Medication	Dosage	Frequency	Reasoning

Allergies: □ Check here if none		

Social Information:		
Tobacco:	What is your current smoking status?	□CURRENT □FORMER □NONSMOKER
	If current smoker, how many per day?	
	If former smoker, when did you quit?	/ /
Alcohol:	Do you drink wine, beer, or liquor?	□YES □NO
	If yes, how many drinks per week?	
Drugs:	Do you currently use recreational drugs?	
	If so, what type?	

Height: _____ **Weight:** _____

General

___ Weakness
___ Lack of appetite
___ Weight Loss

Eyes

___ Decreased ability to see
___ Loss of vision

Skin

___ Change in skin color or temperature
___ Hair growth change, ulcers
___ Nail changes
___ Skin ulcers

Respiratory

___ Asthma
___ Shortness of breath at rest
___ Shortness of breath with exertion

Cardiovascular

___ Chest pain/tightness/ squeezing, irregular heartbeat
___ Need to sit up to breathe
___ Irregular heart beat (palpitations)
___ Swelling of the legs
___ Varicose Veins
___ Heaviness
___ Achiness
___ Fatigue
___ Leg pain at rest
___ Leg pain with exertion
___ Blue/purple discoloration of hands/feet

Gastrointestinal

___ Nausea
___ Vomiting
___ Diarrhea
___ Abdominal pain
___ Abdominal pain after eating
___ Blood in stools

Genito-urinary System

___ Pain or burning on urination
___ Frequent urination
___ Unusually large volumes of urine
___ Extreme urge to urinate

Endocrine

___ Heat intolerance
___ Cold intolerance
___ Increased thirst

Musculoskeletal

___ Neck Pain (Bone, joint or muscle problems)
___ Back pain
___ Right arm pain
___ Left arm pain
___ Pain down your legs
___ Right leg pain
___ Left leg pain
___ Painful joints
___ Deformities of the joints or extremities

Neurologic

___ Weakness, headaches, pre-syncope, syncope
___ Blackouts
___ Dizziness
___ Double vision
___ Numbness or tingling of the extremities
___ Paralysis or weakness of limbs
___ Loss of sensation
___ Loss of balance or coordination
___ Problems speaking

Psychiatric

___ Depression
___ Anxiety

Contact Precaution

___ HIV
___ Hepatitis C
___ MRSA
___ C-DIFF
___ Norovirus
___ TB
___ Measles
___ Chicken pox
___ Staphylococcus Aureus

PAST MEDICAL HISTORY: PLEASE CHECK WHETHER YOU HAVE EVER HAD THE FOLLOWING:

	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	☐	☐	Ulcers (GI)	☐	☐
Clotting Disorder	☐	☐	Kidney Disease	☐	☐	Vitamin D deficiency	☐	☐
COPD	☐	☐	Meningitis	☐	☐			
Dementia	☐	☐	Myocardial Infarction	☐	☐			
Depression	☐	☐						

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

_____

_____

PAST SURGICAL HISTORY: PLEASE CHECK WHETHER YOU HAVE HAD THE FOLLOWING:

	NO	YES		NO	YES		NO	YES
Appendectomy	☐	☐	C-Section	☐	☐	Small intestine surgery	☐	☐
Brain Surgery	☐	☐	Eye surgery	☐	☐	Spine surgery	☐	☐
Breast Surgery	☐	☐	Fracture Surgery	☐	☐	Tonsillectomy	☐	☐
CABG	☐	☐	Hernia repair	☐	☐	Tubal ligation	☐	☐
Cholecystecomy	☐	☐	Hysterectomy	☐	☐	Valve replacement	☐	☐
Colon Surgery	☐	☐	Joint Replacement	☐	☐	Vasectomy	☐	☐
Prostate Surgery	☐	☐						

Other: please list

PLEASE LIST ANY OTHER SURGERIES: _____

FAMILY HISTORY: PLEASE LIST ANY SIGNIFICANT FAMILY MEDICAL HISTORY (i.e. Diabetes, Hypertension, Stroke, Clotting Disorders, Kidney Failure, etc.

Mother:

Father:

Siblings:

Children: