Garvey Vascular Specialists
comprehensive
results oriented

PRE-VISIT FORM

Patient Information

Patient Name:

_____
Last Name First Name Middle

Referring Physician: _____

Date of Birth: _____/_____/_____ Age: _____ Occupation: _____

Height: _____ft _____in Weight: _____ Gender: (____) Male (____) Female

Number of Pregnancies: _____

PERSONAL HEALTH HISTORY

What is the reason for this visit?

_____

Have you ever had a heart problem? (____)Yes (____)No If yes, explain: _____

List medications you are currently taking:

_____ _____
_____ _____
_____ _____

Do you have any allergies to medication? (____)Yes (____)No If yes, which medications: _____

Describe any surgeries you have had:

_____
_____
_____
_____

Please check any other health conditions you have or have had in the past:

Miscellaneous

- ☐ Diabetes/high blood sugar: Date diagnosed:
- ☐ Cholesterol: Level
- ☐ Low blood sugar
- ☐ Hypertension
- ☐ Arthritis
- ☐ Urinary problem
- ☐ Kidney disease

Do you currently smoke? (____)Yes (____)No If yes, how much? _____

Have you ever smoked? (____)Yes (____)No If yes, how much and when did you quit? _____