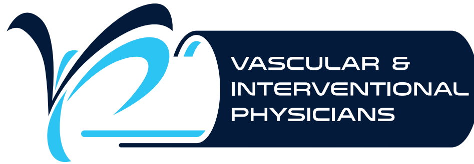


Aubrey M . Palestrant, MD, FSIR / Aaron Wittenberg, MD / John Eelkema, MD / Gaurav M. Patel, MD
William Romano, MD, FSIR / Vineel Kurli, MD / Gregory Titus, MD

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE IN FULL.
THE INFORMATION YOU PROVIDE IS IMPORTANT FOR YOU CARE.

PATIENT NAME____DATE OF BIRTH______________DATE_______________

ADDRESS____

PHONE NUMBER_______________________________________EMAIL____

MARITAL STATUS ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

OCCUPATION___________________________IF RETIRED, WHAT WAS YOUR OCCUPATION______________________

HOW DID YOU HEAR ABOUT US____

PRIMARY CARE PHYSICIAN_____________________________REFERRING PHYSICIAN___________________________

WHAT MEDICAL PROBLEM BROUGHT YOU HERE?____

HOW LONG HAVE YOU HAD THIS?____

HAVE YOU BEEN TREATED FOR THIS PREVIOUSLY?____

PATIENT DEMOGRAPHICS

PREFERRED LANGUAGE_________________________________GENDER___________________RACE_______________

PERSONAL HISTORY AND RISK FACTORS

1. DO YOU HAVE DIABETES, HIGH BLOOD SUGAR OR SUGAR IN YOUR URINE? ☐NO ☐YES

   IF YES, WHAT WAS THE AGE OF ONSET?

   HOW DO YOU CONTROL YOUR DIABETES? ☐DIET ☐PILLS ☐INSULIN

   ARE YOU TAKING METFORMIN OR GLUCOPHAGE? ☐NO ☐YES

2. DO YOU HAVE HIGH BLOOD PRESSURE? ☐NO ☐YES SINCE WHEN?________

   ARE YOU ON BLOOD PRESSURE MEDICATION? ☐NO ☐YES SINCE WHEN?________

3. DO YOU HAVE DVT (BLOOD CLOTS)? ☐NO ☐YES SINCE WHEN?________

   ARE YOU ON BLOOD THINNERS? ☐NO ☐YES SINCE WHEN?________

   IF YES, WHAT IS THE NAME OF THE MEDICATION YOU ARE TAKING?_______________________________________

4. HAVE YOU HAD ANY OF THE FOLLOWING:

HEART ATTACK	☐NO	☐YES	WHEN?______________
STROKE	☐NO	☐YES	WHEN?______________
ANGIOPLASTY	☐NO	☐YES	WHEN?______________
PERIPHERAL VASCULAR DISEASE	☐NO	☐YES	WHEN?______________

5 ARE YOU NOW OR HAVE YOU EVER BEEN A CIGARETTE SMOKER? ☐NO ☐YES

PACKS PER DAY__________YEARS SMOKED_____________IF YOU QUIT, WHEN?______________________________

DO YOU CONSUME ALCOHOL (BEER, WINE, LIQUOR)? ☐NO ☐YES

HOW MUCH PER DAY?_________________PER WEEK?_________________HOW OFTEN?______________________

DO YOU USE RECREATIONAL DRUGS? ☐NO ☐YES HOW OFTEN?______________________

YOUR PAST MEDICAL HISTORY

LIST AND DATE ANY PAST MAJOR ILLNESSES, OPERATIONS AND HOSPITALIZATIONS

____

____

____

____

FAMILY HISTORY

DESCRIBE YOUR FAMILY'S HEALTH

RELATIONSHIP	ALIVE	DECEASED	MAJOR HEALTH PROBLEMS
FATHER			
MOTHER			
BROTHER			
SISTER			
CHILDREN			

MEDICATIONS

LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING.

PLEASE INCLUDE OVER THE COUNTER, PRESCRIPTIONS AND VITAMINS.

NAME OF DRUG	DOSAGE	FREQUENCY

ALLERGIES

DESCRIBE ANY ALLERGIES TO MEDICATION AND THE REACTION YOU EXPERIENCE

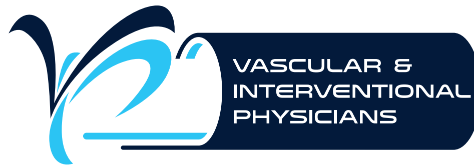
OTHER ALLERGIES

CHECK ANY PROBLEMS THAT YOUR ARE CURRENTLY EXPERIENCING

☐HEADACHES
☐SEIZURES OR EPILEPSY
☐DIZZINESS
☐STROKE
☐FAINTING
☐PROBLEMS WITH SPEECH
☐WEAKNESS IN ARMS OR LEGS
☐NUMBNESS IN ARMS OR LEGS
☐HEARING LOSS
☐VISUAL PROBLEMS
☐DOUBLE VISION

☐CHEST PAIN
☐IRREGULAR HEART BEAT
☐CONGESTIVE HEART FAILURE
☐PNEUMONIA
☐ASTHMA
☐SHORTNESS OF BREATH
☐BRONCHITIS
☐EMPHYSEMA
☐BLOOD IN THE SPUTUM
☐TUBERCULOSIS
☐VALLEY FEVER

☐SWALLOWING PROBLEMS
☐NAUSEA OR VOMITING
☐HEART BURN/INDIGESTION
☐BLOOD IN STOOLS
☐BLACK BOWEL MOVEMENTS
☐HIATAL HERNIA
☐STOMACH ULCERS
☐HEPATITIS OR LIVER PROBLEMS
☐GALLSTONES
☐UNEXPECTED WEIGHT LOSS
☐CANCER



PERMISSION TO DISCUSS MEDICAL INFORMATION

Do you authorize Vascular and Interventional Physicians & Medical Diagnostic Imaging Group to discuss your care and treatment with any party beside yourself? ☐NO ☐YES

Name______________________________Relationship_______________________________________Number______________

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Medical Diagnostic Imaging Group
Attn: Privacy Officer
P.O. Box 17049
Phoenix, AZ 85011

CONSENT TO LEAVING PHI ON TELEPHONE MESSAGING SERVICES

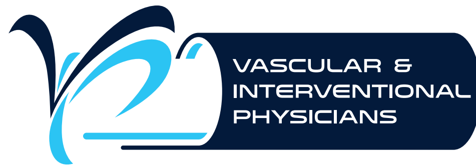
At the discretion of Medical Diagnostic Imaging Group & Vascular and Interventional Physicians, its employees, medical staff, and agents (MDIG & VIP) and upon your agreement to the terms outlined within this consent form, you authorize (MDIG & VIP) to leave protected health information (PHI) on voice mail or other telephone messaging services. These messages may contain your personal health information such as test results and medication changes. If you authorize this, you should be aware that voice mail and other telephone messaging services are not secure or private, and such, unauthorized people may be able to retrieve and hear such communications.

I understand that information used to or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. By signing this form, I authorize you to disclose the protected health information described above.

Patient Name____Date of Birth__________

Signature____Date________________

Relationship to patient____



ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Original to be maintained in patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

______________________________	______________________________
Patient or legally authorized individual signature	Date
______________________________	______________________________
Printed name if signed on behalf of the patient	Relationship (Parent, legal guardian, personal representative, etc)

VIP CLINICAL OFFICE • 19636 N 27TH AVE, SUITE 301 • PHOENIX, AZ 85027 • (P) 602.200.9339 • (F) 602.246.8818