Advanced Radiology Services PC

Michael Doherty, MD • Todd Durham, MD • Brian Fedeson, MD • Michael Knox, MD • Jarrod MacFarlane, DO • Jay Morrow, MD
Bryan Mustert, MD • Chirag Patel, MD • William Rozell, DO • William Slater, MD • Jeff VanErp, MD • Manish Varma, MD

New Patient Information

Patient Name: _____

Reason for visit: _____

Date of Birth: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

What prior evaluation have you had for this problem: _____

_____

List any medications (including dosage) that you take on a regular basis:

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medications:

_____

Have you had a reaction to sedation or anesthesia? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

If you are female are you pregnant? ☐ Yes ☐ No
If yes, how many weeks? _____

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Are you currently or have you in the recent past been treated for any of the following medical conditions? (Check all that apply)

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Atrial Fib
☐ Bleeding disorder
☐ Blood Clots
☐ Cancer
☐ Chest Pain/Angina
☐ Chronic Pain
☐ Congenital Disease
☐ CHF
☐ COPD
☐ Dementia
☐ Depression/Anxiety
☐ Diabetes
☐ Diverticular Disease
☐ Elevated Cholesterol/lipids
☐ GERD
☐ Gastrointestinal Bleeding
☐ Glaucoma
☐ Hepatitis
☐ Hypertension
☐ Headache
☐ Inflammatory Bowel Disease
☐ Kidney Stone/Failure
☐ Migraines
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Pneumonia
☐ Pancreatitis
☐ Pulmonary Embolism
☐ Renal Insufficiency
☐ Swelling of Legs
☐ Seizures
☐ Stroke/TIA
☐ Thyroid Disorder

If you have Diabetes:
What type: _____
What treatment are you following: _____

Please list any other medical problems: _____

_____

_____

Have you had any of the following surgeries? (Check all that apply)

☐ Aneurysm Repair/Coiling
☐ Angioplasty/Stent
☐ Appendectomy
☐ Bariatric
☐ Bowel
☐ Bladder
☐ CABG/Heart Valve
☐ Cataract
☐ Gallbladder Removal
☐ Hernia
☐ Hysterectomy
☐ Kidney
☐ Laminectomy
☐ Mastectomy/Lumpectomy
☐ Orthopedic/Joint
☐ Pacemaker
☐ Thyroidectomy
☐ Transplant
☐ Tubal Ligation/Vasectomy
☐ TURP
☐ VP Shunt
☐ Vascular

Please list any surgeries not listed above: _____

_____

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Family History:
Please list any health problems your family members have experienced including cause of death (if deceased):

Father: _____

Mother: _____

Siblings: _____

Social History:
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

Do you use tobacco: ☐ Yes ☐ No
If yes, what types: ☐ Smoke cigarettes ☐ Chewing tobacco ☐ Other (e.g. environmental exposure)
If yes, how often: _____ Have you quit: ☐ Yes ☐ No Date: _____

Do you drink alcohol: ☐ Yes ☐ No
If yes, how often: _____ Have you quit: ☐ Yes ☐ No

Have you experienced any of the following? (Check all that apply)

☐ Abdominal Pain
☐ Back Pain/Injury
☐ Bleeding/Bruising
☐ Blood/Change in your bowel movements
☐ Blood in your urine
☐ Change in your vision
☐ Change in mood/Anxiety/Depression
☐ Chest Pain/Palpitations
☐ Chills
☐ Chronic Cough
☐ Dizziness
☐ Fatigue
☐ Fever/Sweats
☐ Frequency with urination
☐ Headache
☐ Hives, Itching
☐ Joint Pain
☐ Menstrual problems
☐ Nausea
☐ Pain/Cramping in legs when walking
☐ Problems with swallowing
☐ Ringing or buzzing in your ears
☐ Shortness of Breath
☐ Swelling in your legs
☐ Visual changes
☐ Vomiting
☐ Weakness
☐ Weight Loss

This form is accurate and current to the best of my knowledge.

_____ _____
Patient Signature Date